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Senior First Proposal Form

URN: 017

Insurance contract is a legal contract too and it's based on TRUST and We TRUST You.

We understand you may not know how relevant is the information on your health and it's impact on your policy. Hence it's very important that you disclose all health information and we would decide how relevant it is (we call it 'material fact').

We would cancel your policy, will not pay any claim, will not refund any premium paid and have right to take all possible legal action against you including for recovery of benefits paid earlier, if correct and complete information is not provided about all members proposed to be insured.

Regulations mandate that the coverage can start only after we have received the full premium and have explicitly accepted the risk.

1. Proposer Details:

Title ☐ Name FIRST MIDDLE LAST

DOB DDMMYYYY Gender: ☐ Male ☐ Female ☐ Other

Current address

Landmark City/Town

District State Pincode

Mobile number Telephone with STD code

Email ID

PAN Number CKYC number (optional):

Annual income (Rs) Nationality

Occupation ☐ Salaried ☐ Self-employed ☐ Student ☐ Housewife ☐ Other, please specify

Do you want the Physical Copy of the Policy Kit ☐ Yes ☐ No

☐ I will do my bit to preserve the planet for children. I will go green. Send me soft copy only. Strictly no paper please

☐ I wish to have this Policy credited to an eIA.

Existing E-Insurance Account No.

Insurance Repository Name (you have opened your account with)

☐ M/s NSDL Database Management Limited ☐ M/s Central Insurance Repository Limited

☐ M/s Karvy Insurance Repository Limited ☐ M/s CAMS Repository Services Limited (Please select any one) Or

☐ If you wish us to help open an eIA account for you, please fill details in sec 9, NEFT & Bank details Or

☐ I do not have an eIA and do not wish to open one

☐ I authorize Niva Bupa Health Insurance or any of its Agents and/or third party(ies)/affiliates to contact me via SMS/Email/Phone/WhatsApp/ Facebook or any other modes on my registered phone number over-riding my 'DND' registration to make welcome calls/SMS, service calls/SMS, policy related information or any other commercial communication.

Are you or any of the proposed applicants a politically exposed person (PEP) ☐ Yes ☐ No

Rural and Social Sector Category (if applicable): ☐ **ASHA Worker** ☐ **MGNREGA Worker**

#PEP is someone who are or have been entrusted with prominent public functions i.e. Heads / ministers of central or state government, senior politicians, senior government, judicial or military officials, senior executives of government companies, important party officials. (If you have ticked against PEP, kindly fill the separate PEP questionnaire)

2. Details of applicants & plan selection

Choose your plan: Platinum ☐ Gold ☐ Policy Term: ☐ 1 Year ☐ 2 Years ☐ 3 Years

Base Sum Insured: ☐ 5 Lacs ☐ 10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs *Sum Insured Type: Individual ☐ Floater ☐

Applicant 1

Name

Gender ☐ Male ☐ Female ☐ Other Height (ft) (inch) Weight (kg)

Date of Birth DDMMYYYY Mobile number

Relationship to Proposer (Please tick option): Self / Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter

Applicant 2

Name

Gender ☐ Male ☐ Female ☐ Other Height (ft) (inch) Weight (kg)

Date of Birth DDMMYYYY Mobile number

Relationship: Spouse of Applicant 1 ☐

***Floater sum insured is the same for all insured members. Floater means individually or collectively all insureds can claim to this limit**

Emergency contact

Name

Contact No with STD code Mobile number

Optional feature

Co-payment (Base policy has 50% co-payment, however you can reduce it up to 0%) 0% (Add-on) 20% 30% 40%

Annual Aggregate Deductible (Deductible amount will be 1/5th of the Base Sum Insured) Yes No

Add-on(s): Safeguard Yes No

3. Portability

Policy No	Insurance company	Risk start date	Risk end date	Reasons for Porting

Name of proposed insured for whom portability is requested	First policy start date	No of years of continuous coverage for which portability is requested	Claims in past policies	Current No claim Bonus	Sum insured – Year 1 (Oldest)	Sum insured- Year 2	Sum insured – Year 3	Sum insured – Year 4 (Expiring policy)

4. Nomination

In the event of the death of the Proposer, claim shall be paid to the Nominee. For other insured persons, Proposer is the nominee. Payment to the nominee constitutes discharge of the Company's full liability.

Nominee Name	Date of Birth	Relationship with the Proposer	Address, mobile number and email ID of Nominee	Appointee Name (if nominee is less than 18 years of age)

Bank details of Nominee: Beneficiary Name:

Bank name Account type Savings Current

Account number IFSC Code

5. Medical, habits and past proposal information

Section A: In respect of any of the persons proposed to be insured:	Applicant 1	Applicant 2
Has any application for life, health, hospital daily cash or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?	Yes No	Yes No
Section B: Has any of the person proposed to be insured ever been diagnosed with:	**Applicant 1**	**Applicant 2**
i. Heart disease like Heart attack, Heart failure, Ischemic heart disease or Coronary heart disease, Angina etc	Yes No	Yes No
ii. Tumor, Cancer of any organ, Leukemia, Lymphoma, Sarcoma	Yes No	Yes No
iii. Major organ failure (Kidney, Liver, Heart, Lungs etc)	Yes No	Yes No
iv. Stroke, Encephalopathy, Brain abscess, or any neurological disease	Yes No	Yes No
v. Pulmonary fibrosis, collapse of lungs or Interstitial lung disease (ILD)	Yes No	Yes No
vi. Hepatitis B or C, Chronic liver disease, Crohn's disease, Ulcerative colitis	Yes No	Yes No
vii. Any anaemia other than iron deficiency anaemia	Yes No	Yes No
viii. Ever been hospitalized for more than 5 days	Yes No	Yes No
ix. Ever taken any medicines for more than 10 days continuously? Medication includes but not limited to inhalers, injections, oral drugs and external medical applications on body parts.	Yes No	Yes No
x. Awaiting any treatment, surgical or medical that has been advised	Yes No	Yes No

xi. Under any periodic / regular follow up for any disease suffered in past, whether cured or not? Follow up means periodic consultations, investigations etc	Yes ☐ No ☐	Yes ☐ No ☐
xii. Has any consultations with doctor(s) or advised any tests for problems currently having or had in last 30 days?	Yes ☐ No ☐	Yes ☐ No ☐
xiii. Diabetes (high blood sugar), Pre-diabetes, High or low blood pressure, Chest Pain or any heart disease or Thyroid disorder, Asthma, Bronchitis	Yes ☐ No ☐	Yes ☐ No ☐
xiv. Parents have any hereditary or genetic condition? Please mention even if any of them is a carrier state i.e. did not have the disease but was a carrier	Yes ☐ No ☐	Yes ☐ No ☐
xv. Any calculus (stone) disorder in any organ like Gall bladder, Kidneys, Urinary bladder, Ureter etc.	Yes ☐ No ☐	Yes ☐ No ☐
xvi. Tumor (Swelling)-benign or malignant, any external ulcer/growth/cyst/mass anywhere in the body?	Yes ☐ No ☐	Yes ☐ No ☐
xvii. HIV / AIDS, anaemia, thalassemia, haemophilia or any other blood related problem.	Yes ☐ No ☐	Yes ☐ No ☐
xviii. Psychiatric/Mental illnesses or sleep disorder?	Yes ☐ No ☐	Yes ☐ No ☐
xix. Any health condition, disease, symptoms or information pertaining to health that is not captured above. If answer to this question is Yes for anyone, provide all medical documents	Yes ☐ No ☐	Yes ☐ No ☐
xx. Smokes or consumes tobacco / gutkha /pan masala or alcohol If Yes, please answer the following:	Yes ☐ No ☐	Yes ☐ No ☐
i. When did the applicant start smoking / consuming tobacco? a) School b) 10+2 c) College d) When started working e) Later		
ii. How many years since the applicant has been consuming alcohol?		
iii. How many days a week does the applicant consume alcohol? (1/2/3/4/5/6/7)		

6. Declaration (Please read carefully and put a check mark against each before signing the proposal form)

☐ I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorized to propose on behalf of these other persons.

☐ I understand that the information provided by me will form the basis of the insurance Policy, is subject to the Board approved underwriting Policy of the insurer and that the Policy will come into force only after full payment of the premium chargeable.

☐ I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

☐ I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

☐ I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.

☐ I/We authorize the Company to share information pertaining to my / our proposal including the medical records of the Insured / Proposer for the sole purpose of Service Delivery with our empaneled provider.

☐ If the Proposer has signed in vernacular language or has a disability that restricts submitting the form: The content of the form has been explained by me, ___Name of the person certifying in language___, in presence of _____Name of Witness_____ to the proposer who has understood and confirmed the same. Witness must be someone other than the agent / employee of the company.

Date D D M M Y Y Y Y Place _____ Signature of the Proposer

Signature of the certifying person:

Signature of the Witness

Mobile number of the certifying person:

Mobile number of the Witness:

7. Declaration if form is NOT filled by the proposer & Advisor declaration

Declaration if for any reason, the proposal and other connected papers are not filled by the Proposer.
The contents of the proposal form have been fully explained to me and I have fully understood all aspects and implications. The Proposal Form is filled by _____Name_____, _____Mobile No._____ under my instruction and I found all information to be correct & complete.

Signature of the Proposer

Advisor declaration: I as an Insurance Advisor / Specified Person of the Corporate Agent / Authorised employee of the Broker / Relationship Officer, do hereby declare that I have explained all the contents of this product / proposal to the Proposer

Signature of the Insurance Advisor

8. Premium Details (for office use only)

Premium payment option ☐ Cheque ☐ Demand Draft ☐ Credit card / Debit card ☐ Net Banking ☐ Cash ☐ Others

Premium amount ______ Premium paid by ______

Relationship with proposer ______ Online payment transaction ID: ______

Bank name/branch ______ Date DD MM YYYY

Niva Bupa branch location ______ Code No. ______

Business sourced by: Advisor/DST/Corporate Agency/Other Channels Code No ______

Name ______

Proposal received on: DD MM YYYY Customer ID: ______

Is Proposer or the applicant a staff? ☐ Yes ☐ No

9. Details for Refund & Payment of Claims

Option to receive payment: ☐ Bank Transfer

Name of the Beneficiary ______

Bank Name ______

Account No. ______ IFSC Code ______

Account type: ☐ Savings ☐ Current

10. Renewal

Renewal payment sign-up:

Payment of renewal premium of your health insurance Policy can be made every year through continuing your existing Automated Clearing House (ACH) / Standing Instructions (SI) with the Company. Under this option, your Policy can be renewed promptly, but subject to you completing all additional requirements of information and documentation as may be required by the Company.

☐ I want to opt for the ACH/SI renewal option and thereby avail a discount of 2.5% on the premium till the time policy is renewed using the same.

Date DD MM YYYY Place ______ Signature of the Proposer ______

11. Additional details for Bancassurance channel only (for office use only)

Branch Code ______ SP Code ______ RM/LG code ______

Customer account number ______

12. Statutory Warning

Prohibition of Rebates (Under Section 41 of the Insurance Act 1938

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

13. ABHA ID

Member Name	Do you have ABHA ID?	ABHA ID	Consent to share Medical records with insurers/TPA's through ABHA
______	☐ Yes ☐ No	____-____-____-____	☐ Yes ☐ No
______	☐ Yes ☐ No	____-____-____-____	☐ Yes ☐ No

Acknowledgment By The Company

Application No. | | | | | | | | | | | | | | | | | | Date D D M M Y Y Y Y

We acknowledge with thanks the receipt of your proposal and amount by Cheque/Demand Draft/ Others----------of amount of Rs. ---------- dated ----------drawn on---------- Neither the submission to us of a completed proposal for Insurance nor any payment made towards issuance of a Policy obliges us to agree to issue a Policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for Insurance, it shall be subject to the Policy's terms and conditions and we shall have no liability whatsoever if premium is not received by us in full and in time or is not realized. If we do not accept the proposal, we will inform you and refund the payment after deducting cost of medical tests, if any, received from you without interest.

Name and Signature of the receiver and office seal

Niva Bupa Health Insurance Company Limited
Registered office:- C-98, First Floor, Lajpat Nagar, Part 1, New Delhi-110024

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