170000025006

niva Bupa Health Insurance

ReAssure 2.0
Proposal Form

URN: 023

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 its impact on your policy. Hence, it is 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

DOB D D M M Y Y Y Y Gender: Male Female Other Nationality

Current address

Landmark City

District State Pincode

Landline number Mobile number

Email ID Alternate number

PAN Number

Annual income (Rs) CKYC Number

Occupation Salaried Self-employed Student Housewife Other, please specify

Premium paid by Relationship with Proposer

I would like to protect the environment and help save paper by authorizing the Company to send all your Policy and service related communication to the email ID as mentioned here in the application form?

I have read, understood and accepted all Terms and Conditions & hereby 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 or any other commercial communication.

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

Are you or any of the proposed applicants a PEP#? Yes No

#Politically Exposed Persons (PEP) are individuals 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)

Bank details:

Bank name

Account number IFSC Code

Account type Savings Current Branch City

Details of Electronic Insurance Account (eIA)

Do you wish to have this Policy credited to an eIA? (Please select any one)

No, I do not have an eIA and do not wish to open one Yes, Credit this Policy to my e-Insurance account

If yes, Please share existing e-Insurance Account No.

Please select 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

I do not have existing e-Insurance account and I am interested in creating a new e-Insurance account
(Please submit electronic insurance account opening form (eIA form) along with relevant documents).

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

2. Details of applicants for insurance:

Applicant 1

Name

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

Mobile number Date of Birth D D M M Y Y Y Y Please tick if not Indian

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

If a registered Medical Practitioner*, please provide: i. Medical Registration Number

ii. Council Name

iii. Address of workplace

Applicant 2

Name

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

Mobile number Date of Birth D D M M Y Y Y Y Please tick if not Indian

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

If a registered Medical Practitioner*, please provide: i. Medical Registration Number

ii. Council Name

iii. Address of workplace

Applicant 3

Name

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

Mobile number Date of Birth D D M M Y Y Y Y Please tick if not Indian

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

If a registered Medical Practitioner*, please provide: i. Medical Registration Number

ii. Council Name

iii. Address of workplace

Applicant 4

Name

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

Mobile number Date of Birth D D M M Y Y Y Y Please tick if not Indian

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

If a registered Medical Practitioner*, please provide: i. Medical Registration Number

ii. Council Name

iii. Address of workplace

Applicant 5

Name

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

Mobile number Date of Birth D D M M Y Y Y Y Please tick if not Indian

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

If a registered Medical Practitioner*, please provide: i. Medical Registration Number

ii. Council Name

iii. Address of workplace

Applicant 6

Name

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

Mobile number Date of Birth D D M M Y Y Y Y Please tick if not Indian

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

If a registered Medical Practitioner*, please provide: i. Medical Registration Number

ii. Council Name

iii. Address of workplace

** Avail a discount of 5% on the premium. Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.*

Notes: *1. If the relationship of Applicant 1 with Proposer is employee, then the relationship of other Applicants are with Applicant 1.*

3. Coverage selection:

Base coverage:

Policy type#:	☐ Individual ☐ Family Floater ☐ Multi Member Individual
Number of lives to be covered:	☐☐ Adults ☐☐ Children
Variant:	☐ Bronze ☐ Silver ☐ Gold ☐ Bronze+ ☐ Silver+ ☐ Gold+ ☐ Diamond+ ☐ Platinum+ ☐ Titanium+
Base Sum Insured:	_____
Policy term:	☐ 1 Year ☐ 2 Years ☐ 3 Years

Optional coverage:

1. Hospital Cash	☐ Yes ☐ No
2. Safeguard$	☐ Yes ☐ No
3. Safeguard+$	☐ Yes ☐ No
4. Smart Health+ (Disease management) *All affected members to choose one variantgold or platinum.	☐ **Gold** ☐ **Platinum** ☐ **No** **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐
5. Smart Health+ (Acute Care) *any one of the two can be opted	☐ **Best Consult** ☐ **Best Care** ☐ **No** **INR 5,000** ☐ **INR 10,000** ☐ **INR 15,000** ☐ **INR 20,000** ☐
6. Personal Accident Cover Please tick if opting for 'Personal Accident Cover' *(This option is available only to Applicants of age 18 years or above)*	☐ **1X** ☐ **2X** ☐ **3X** ☐ **4X** ☐ **5X** **Applicant 1** ☐ **Applicant 2** ☐ **Applicant 3** ☐ **Applicant 4** ☐ **Applicant 5** ☐ **Applicant 6** ☐
7. Annual Aggregate Deductible Options:	**No** ☐ **10,000** ☐ **20,000** ☐ **30,000** ☐ **50,000** ☐ **1,00,000** ☐
8. Co-Payment	☐ No ☐ 20% ☐ 30% ☐ 40% ☐ 50%
9. Pre-Existing Disease Waiting Time Modification	☐ No ☐ 2 Year ☐ 1 Year
10. Room Type Modification	☐ No ☐ Single Private Room ☐ Shared Room
11 Tiered Network	☐ No ☐ Yes
12. Prolonged Treatment Assistance Cover *Compassionate Visit* *Accommodation Benefit* *Convalescence Benefit*	☐ No ☐ Yes ☐ INR 5,000 ☐ INR 10,000 ☐ INR 15,000 ☐ INR 20,000 ☐ INR 25,000 Sum Insured: INR _____ Number of Days: _____ Sum Insured: INR _____
13. Prolonged Treatment Assistance Cover	☐ No ☐ Yes

#Family Floater sum insured is common for all insured members. Floater means individually or collectively all insureds can claim to this limit$ Either Safeguard or Safeguard+ can be opted

4. 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)

5. Nomination

In the event of the death of the Proposer, any payment due under the Policy shall become payable to the Nominee named below. The receipt of such payment by the Nominee would constitute discharge of the Company's liability under the Policy.

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

6. Medical, habits and past proposal information

IMPORTANT: Please ensure that all the questions in this section are answered truthfully and completely as the information you provide here will form basis of underwriting by Niva Bupa. Please note any incomplete, incorrect, partially correct information may affect your medical claim and/or coverage.

SECTION A: Please share information on medical conditions

Please answer the following questions for each applicant. Please circle Yes (Y) or No (N)	Applicant Number											
	1		2		3		4		5		6	
i. Other than common cold, flu, infections, minor injury or other minor ailments; has the Applicant ever been diagnosed with any disease and / or hospitalized for more than 5 days and / or undergone / advised to undergo any surgical procedures and / or taken any medication/ had any symptoms for more than 14 days? Medication is including but not limited to inhalers, injections, oral drugs and external medical applications on body parts.	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ii. Has the Applicant ever had adverse findings to any diagnostic tests or investigations related to Thyroid Profile, Lipid Profile, Treadmill test, Angiography, Echocardiography, Endoscopy, Ultrasound, CT Scan, MRI, Biopsy and FNAC?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
iii. Does the Applicant have diabetes or pre-diabetes or has he/she EVER had high blood sugar?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
iv. Does the Applicant have Hypertension or High Blood Pressure?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
v. Has the Applicant ever been diagnosed or treated for any genetic / hereditary disorders or HIV / AIDS?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
vi. Has the Applicant ever been diagnosed or treated for any mental/ psychiatric disorders?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
vii. Has any proposal for life, health, hospital daily cash or critical illness insurance on the life of the Applicant ever been declined, postponed, loaded or subjected to any special conditions such as exclusions by any insurance company?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

SECTION B: (Please fill this section only if the Applicant smokes or consumes tobacco / gutkha/pan masala or alcohol)	i. Chewable tobacco / Gutkha / Pan Masala. If yes, please specify number of pouches per day		ii. Alcohol. If yes, please specify number ml per week			iii. Cigarettes / Bidi / Cigar. If yes, please specify consumption per day	
	1-10	> 10	<= 450	> 450	Daily Drinker	1-10	> 10
Applicant 1							
Applicant 2							
Applicant 3							
Applicant 4							
Applicant 5							
Applicant 6							

SECTION C: For questions marked Yes (Y) in Section A, please specify following information:										
Applicant Number	Details of symptom(s) or investigation(s) or diagnosis or procedure / surgery undergone					Medication(s)	Dosage	Current status (e.g. Complete/ partial recovery or ongoing treatment)	Treating doctor's name & contact details	Documents attached (Yes/No)
	If Diabetes HbA1c Level	If High blood pressure BP Level		Any Other Details	Onset date (DD/ MM/ YYYY)					
		Systolic	Diastolic							

7. 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.

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

8. Vernacular Declaration

(Certification in case the Proposer has signed in vernacular (to be witnessed by someone other than agent/ employee of the Company)).
The content of this form and its particulars have been explained by me in vernacular to the Proposer who has understood and confirmed the same:

Name of the certifying person:

Signature of the certifying person:

Mobile number of the certifying person:

Name of the Witness

Signature of the Witness

Mobile number of the Witness:

Signature of the Proposer

9. Proposer Declaration

(Certification where for any reason, the proposal and other connected papers are not filled in by the Proposer).
The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract. The Proposal Form is filled by _____ under my instruction and I found it to be correct and complete.

Signature of the Proposer

10. Premium Details (for office use only)

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

Premium amount ____ Online payment transaction ID: ____ Date D D M M Y Y Y Y

Bank name/branch ____ Niva Bupa branch location ____

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

Code No ____

Name ____

Proposal received on: D D M M Y Y Y Y Customer ID: ____

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

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

Branch Code ____ SP Code ____ RM/LG code ____

Customer account number ____

12. Insurance advisor's report (for office use only)

I, in my capacity 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 Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy.

I have further explained that if any untrue statement(s) / information / response(s) is / are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished / to be furnished and further more if there has been a non-disclosure of any material fact, the policy issued to his / her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

Date D D M M Y Y Y Y Signature of the Insurance Advisor ____

13. 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.

14. Rural and Social Sector Category (if applicable):

ASHA Worker ☐ MGNREGA Worker ☐

15. 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
	☐ Yes ☐ No	__ - __ - __ - __	☐ Yes ☐ No
	☐ Yes ☐ No	__ - __ - __ - __	☐ Yes ☐ No
	☐ Yes ☐ No	__ - __ - __ - __	☐ Yes ☐ No
	☐ Yes ☐ No	__ - __ - __ - __	☐ Yes ☐ No

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

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16. Details for Refund & Payment of Claims

Option to receive payment: ☐ **Bank Transfer**

Name of the Beneficiary

Bank name

Account number

IFSC Code

Account Type

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

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Product Name: ReAssure 2.0, Product UIN: NBHHLIP27054V032627 | Rider Name: Smart Health+, Rider UIN: NBHHLIA22164V012122
Add-on Name: Tiered Network, Add-on UIN: NBHHLIA25039V012425 | Add-on Name: Xtend, Add-on UIN: NBHHLIA26052V012526

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