Proposer Details

Name

Address

City State Pin

Phone
Residence Office Fax

Mobile E-mail

PAN No. Occupation : ☐ Business ☐ Service ☐ Not Employed ☐ Student

Policy Opted ☐ Individual ☐ Group ☐ Family Medicare ☐ Top-Up ☐ Super Top-Up

(Please refer page 5 for additional information on selected policy)

Service Tax Regn. No. Total Number of Persons to be covered

(Please fill-up details as per the schedule attached)

Sl. No.	Name	Age	Gender	Relationship with Proposer	Occupation	Sum Insured*
1						
2						
3						
4						
5						
6						
7						

** If Family Medicare, floater sum Insured to be indicated.*

Policy Commencement Date D D M M Y Y Y Y

Has any proposal for this insurance or any other health insurance been refused or cancelled or higher premium charged. If so, give details.	☐ Yes ☐ No

Place

Date D D M M Y Y Y Y

Signature of Proposer

For Official Use only

Name

TPA Code :

Intermediary Code :

Insured Person Details

PLEASE FILL WITH BLOCK LETTERS

** If more than one person is to be covered, please take additional copies of this form and complete the same for each insured person*

Name

Address

City State

Pin Code DOB D D M M Y Y Y Y Age

Height in cms. Weight in kgs. BMI Blood Group

Affix passport size photograph here

(III) LIFESTYLE :

Smoking	Alcohol	Food	Sports Activities	Regular Exercise	Recreation
☐ 1 Pack/day ☐ Less Than 1 Pack/day	☐ Habitual ☐ Social ☐ Nil	☐ Veg. ☐ Non-Veg.	☐ Cricket ☐ Hockey ☐ Foot Ball ☐ Others	☐ Gym ☐ Walking	Are you a Member of a Health Club ☐ Yes ☐ No

(IV) INSURANCE HISTORY (last 5 years)

Date of first policy :

Name of the Insurance Co.	Policy No.	Type of Policy	Period of Insurance	Sum Insured	Claim Amount	Reason for Claim	NCB/CB

Whether any insurance company has refused/cancelled a policy ? ☐ Yes ☐ No

PRE-ACCEPTANCE TESTS APPLICABLE ABOVE 45 YEARS (Enclose Test Reports).

Lipid Profile	
2.	
3.	

Place

Date D D M M Y Y Y Y

Specimen Signature

DIABETES

Date of Diagnonis	
Did you suffer from coma or procoma ?	
Do you take any anti diabetic drugs ? If so, please give names with dosage.	
Please give details of Fasting and post prandial Blood Sugar readings.	

HYPERTENSION

What is your Blood Pressure reading? Please state with dates.	
Please state name of antihypertensive drugs with dose.	
Are you a smoker ?	☐ Yes ☐ No
Is it essential/secondary/malignant Hyertension	
Please state whether you have suffered from any complications or other diseases.	

CARDIAC HISTORY

Did you ever suffer from chest pain or coronary insufficiency or myocardial infarction ? If so, please give diagnosis and date.	
Please state name and dose of drugs you are taking at present.	
Please state the findings with dates of investigations done like ECG, Stress Test, Coronary Angiography, X-ray, Pathology reports, etc., Please send reports with the prescribed form.	

Have you suffered from or are suffering from any illness during past 48 months (Prior to the inception of this policy	☐ Yes ☐ No
If yes, give details :	

TO BE COMPLETED BY CONSULTING PHYSICAN / SURGEON *(Reports to be attached)*

Name of the Patient	Complaint / Investigation	Treatment		Past Treatment			Recommended for Insurance
		Medication	Any Other	Surgery	Medication	Any Other	

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Qualification ☐☐☐☐☐☐☐

Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ City ☐☐☐☐☐☐☐☐

State ☐☐☐☐☐☐ Pin ☐☐☐☐☐☐ Contact No. ☐☐☐☐☐☐☐☐☐☐

Place ☐☐☐☐☐☐☐☐

Date D D M M Y Y Y Y

Signature of the Medical Practitioner

Additional Details Required

PLATINUM / GOLD / SR. CITIZEN / FAMILY MEDICARE	
Floater Sum Insured (For Family Medicare only)	
Add-on Covers Opted - Hospital Daily Cash	☐ 750 ☐ 500
- Ambulance Charges	☐ Yes ☐ No

GROUP POLICY	
Number of Persons	
Extensions Opted - Maternity Benefits	
Claims Experience	

No. of Persons	Discount
101-1000	10.00%
1001-3000	12.50%
3001-6000	15.00%
6001-10000	17.50%
10001-15000	20.00%
15001-25000	25.00%
Above 25000	30.00%

TOP-UP POLICIES

You are opting for	☐ Top-up Policy ☐ Super Top-up Policy
Do you wish to have Policy on	☐ Individual Basis ☐ Family Basis
	Parents can be taken under a separate policy.

If on Individual basis, indicate option for each individual person

Self	A	B	C	D	E	F	G	H
Spouse	A	B	C	D	E	F	G	H
Child-1	A	B	C	D	E	F	G	H
Child-2	A	B	C	D	E	F	G	H
Child-3	A	B	C	D	E	F	G	H

Option	Sum Insured	Specified Threshold Level
A	3,00,000	2,00,000
B	5,00,000	2,00,000
C	3,00,000	3,00,000
D	5,00,000	3,00,000
E	7,00,000	3,00,000
F	5,00,000	5,00,000
G	10,00,000	5,00,000
H	15,00,000	5,00,000

Are any of the Insured person(s) at present or have been at any other time in the past covered under any Medical Expenses Reimbursement Scheme. *(A brief note giving details of the scheme will help in better evaluation of your proposal)*	☐ Yes ☐ No

Please furnish the following (Strike-off wherever not applicable) :

Scheme provided by :	☐ Employer ☐ Others	
Name of the Employer		Others :
Persons Covered	All those who are proposed for coverage under this policy (or) only some persons.	
Expenses Reimbursed	Any hospitalisation / only specified diseases	
Amounts		

Names of the persons covered under the scheme	Eligible Reimbursement Amount	Remarks

Claim amounts received/receivable in preceding five years including expiring policy / reimbursement scheme :

Name of the Insurer / Reimbursement Provider	Policy No. / Scheme Name	Period of Hospitalisation	Illness	Claimed Amount	Amount settled/pending for settlement	TPA, if Applicable

Place ☐☐☐☐☐☐☐☐

Date D D M M Y Y Y Y

Signature of Proposer