

Relationship Beyond Insurance Bajaj Allianz General Insurance Co. Ltd. G.E. Plaza, Airport Road, Yerawada, Pune - 411 006.

IMD Code

For Office Use Only:												
	Scrutiny No.	Receipt No.	Policy No.									

For Agent Use Only:									
Sub IMD Code	IMD Name	Mobile No.							

HEALTH GUARD INDIVIDUAL POLICY PROPOSAL FORM

Loan Account

Number

Instructions For Filling Up The Form:-

For Agent Use Only:

- Please answer all questions in BLOCK letters
- 2. The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid

Emp/LG Code

This Proposal will be the basis of any subsequent policy that we issue to you. It is therefore essential that you provide all the information in this Proposal FULLY AND ACCURATELY and that you provide us with any and all additional information relevant to risk to be insured or our decision as to acceptance of the risk or the terms 3.

	upon which it should be accepted														
Pr	Proposer Details														
1)	1) Full Name: Title			First Name											
Mi	Middle Name			Surname											
2)	2) Are you an existing Bajaj Allianz Customer: Yes / No If yes, please mention the Policy No: OG														
3)	3) Gender: Male Female Other 4) [Date of Birth D	O M N	A Y Y Y	7 J PAN 1	No.									
6)	6) UID/Unique ID: 7) Bajaj Allianz Employee Code, if Proposer is BAGIC/BALIC Employee														
8)	8) Marital Status: Married Single Divorced Widowed 9) No. of Children Sons Daughters														
10]	10) Occupation Business Salaried Profes	ssional Stude	nt 🗌	House Wife	Retired Ot	:hers									
11	11 a) Permanent / Residential Address			11 b) Correspon	idence Address: (A	ll the communic	ations will be se	ent to the belov	w address)						
Но	House No. House Name			House No.		House Name									
	Landmark/			Landmark/ Locality											
Ro	Road/ Area Name			Road/ Area Name											
	City/District			City/District				- 							
	State Pin Code			State		P	Pin Code								
	Tel.			Tel.(Res.)											
				, , <u>l</u>											
	Mobile			Tel.(Office)											
En	Email			Mobile Number											
				E-Mail											
12	12) Educational Qualification: Matriculate	Under Graduat	e	Graduate		Post Graduate	P	rofessionally	Qualified						
13	13) Family Monthly Income: Up to Rs. 20,000	Rs. 20,001 to Rs	s. 50,000	Rs. 50,001	to Rs. 1 lakh	Above Rs. 1 la	kh								
14	14) In case of any Offer, you would prefer to be contacted	by: Phone	Email	15)Nationality											
16	16) Details of the persons to be insured														
Sr	_ Name (dd/mm A	ge Gender Ht	Wt	Occupation	Relation	Sum Insured	Premium	Nominee	Relationship of Nominee						
No	(yy)	(IVI/T)				insureu			of Northinee						
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 17	17) Period of Insurance: From D D M M Y Y		р м	I _M I _Y I _Y I _V											
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	18) Co-Payment (Waiver for non-network Hospitals)19) Do you smoke cigarettes or consume tobacco (chewing)		nicotine	or mariiuana in ai	nv form?			ПΥ	es No						
	Please give duration and daily consumption														
20	 Has any of the persons to be insured suffer from/or in Disorder of the heart, or circulatory system, chest pair 				niratory conditions	cancer tumor	· lumn of any	kind diahet	es						
	hepatitis, disorder of urinary tract or kidneys, blood di	isorder, any mental	or psychi	atric conditions, a	ny disease of brain	or nervous sy									
21	backache, any congenital/ birth defects/ urinary disea 21) Have you or any of your immediate family members (•		•	3		at What age?		es No						
	Prior to age 60yrs?	,		,ave, maa ce	detack,	and and		,	es No						
If y	If yes please provide details														

22) Please	confirr	n, if ar	ny of th	ne pe	13011	ו נט טו	ems	sureu	ı ıs pı	cgnc	(.		ziriaic	,						arry r	monuns	· f							7 v	s	No																																					
23) Do you treatme															ints/	met w	ith a	ny aco	ciden	t in	thepast	: 4 year	s and	hav	e bee	en tak	ing] Ye	_	No																																					
24) Illness/	iniurv	details	s of the	nasi	t 4ve	ars a	and r	nrior	to 4 v	/ears	S.																																																									
/injury suffer							Name of the Illness /injury suffered / suffering in the past 4 years				me of the Illness njury suffered / uffering in the				Name of the Illness /injury suffered / suffering in the			Name of the Illness /injury suffered / suffering in the			Name of the Illness /injury suffered / suffering in the			Name of the Illness /injury suffered / suffering in the			Name of the Illness /injury suffered / suffering in the			Name of the Illness /injury suffered / suffering in the			Name of the Illness /injury suffered / suffering in the			Name of the Illness /injury suffered / suffering in the			Name of the Illness /injury suffered / suffering in the			Name of the Illness /injury suffered / suffering in the			ame of the Illness injury suffered / suffering in the			Treatmen			etails		Date first treated			Name of the Illness / injury suffered any time in the past (prior to 4 years)			Treatment details			Date fi			Current Sta of the Illne Diseases/Ir		ess/	
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25) Has any details	, , ,	osal fo	or life, c	ritica	al illn	ness c	or he	ealth	relate	ed in	surar	nce o	n you	ır life o	r lives	ever l	been	postp	onec	d, de	eclined	or acce	pted	on s	pecia	ıl tern	ns?	If yes	, give	<u> </u>																																						
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^{***} This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer.

** Please read declaration wordings carefully before signing the proposal form.

PORTABILITY FORM

F	PARTI														
1)	Name of the Policyholder / insured (s)_														
2)	Date of Birth / Age														
3)															
4)	Details of existing insurer														
	i. Name of the product														
	ii. Sum Insured														
	iii. Cumulative Bonus														
	iv. Add ons/Riders taken														
	v. Policy Number														
5)															
ŕ	i. Name of the product proposed/inten	ded to take													
	iii. Whether Cumulative Bonus to be co														
6)															
7)															
	·					Period of	Incurance								
	m	Details of Previous Health	Health ID	Sum	ım —		ilisurance	First Policy							
	First Name of Insured	Insurance Policy / Policy No.	Card number	Insured	СВ	From To dd/mm/yyyy dd/mm/yyyy		inception							
						uu,, yyyy	uu,,,,,,,	date							
L															
End	closure: Photocopy of the existing policy	documents													
			Signature of	Proposer											
Dat	te D D M M Y Y Y		J	·											
F	PART II														
1.	,	ınd exclusion have longer exclusion pe	eriod than existi	ng policy				Yes / No							
	(Please indicate Yes /No)														
2.	If yes , please give written consent to th	ne declaration below:													
"l a	im aware that the waiting period for the	following disease (s)/ treatment (s) is .	days/years n	nore than the	previous policy	terms, I herek	by agree to obs	serve the							
ado	ditional waiting period for the following o	diseases (s)/ treatments (s)													
				Г											
			Signature of Po	licyholder											
			•	-											