Health Premia
Proposal Form

160150000226

niva Health Insurance

URN: 008

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

Aadhaar Number (Optional) PAN Number
(Mandatory for premium above Rupees 1 lac)

Annual income (Rs)

Employment: Salaried Self-employed Student Housewife Other, please specify

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

Premium paid by Relationship with Proposer

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 e-Insurance account? (Please select any one)

No, I do not have an e-insurance account 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)

1. NSDL 2. CIRL 3. KARVY 4. CAMS (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).

2. Details of Applicants for Insurance:

Applicant 1

Name

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

Waistline (inch) Date of Birth D D M M Y Y Y Y Mobile number

Please tick if not Indian Passport Number

Relationship to Proposer (Please tick option): Self/Spouse/Son/Daughter-in-law/Daughter/Son-in-law/Father/Mother/Father-in-law/Mother-in-law/Grandfather/Grandmother/Grandson/Granddaughter/Brother/Sister/Sister-in-law/Brother-in-law/Nephew/Niece/Employer-Employee

Applicant 2

Name

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

Waistline (inch) Date of Birth D D M M Y Y Y Y Mobile number

Please tick if not Indian Passport Number

Relationship to Proposer (Please tick option): Self/Spouse/Son/Daughter-in-law/Daughter/Son-in-law/Father/Mother/Father-in-law/Mother-in-law/Grandfather/Grandmother/Grandson/Granddaughter/Brother/Sister/Sister-in-law/Brother-in-law/Nephew/Niece/Employer-Employee

Applicant 3

Name

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

Waistline (inch) Date of Birth D D M M Y Y Y Y Mobile number

Please tick if not Indian Passport Number

Relationship to Proposer (Please tick option): Self/Spouse/Son/Daughter-in-law/Daughter/Son-in-law/Father/Mother/Father-in-law/Mother-in-law/Grandfather/Grandmother/Grandson/Granddaughter/Brother/Sister/Sister-in-law/Brother-in-law/Nephew/Niece/Employer-Employee

Applicant 4

Name

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

Waistline (inch) Date of Birth D D M M Y Y Y Y Mobile number

Please tick if not Indian Passport Number

Relationship to Proposer (Please tick option): Self/Spouse/Son/Daughter-in-law/Daughter/Son-in-law/Father/Mother/Father-in-law/Mother-in-law/Grandfather/Grandmother/Grandson/Granddaughter/Brother/Sister/Sister-in-law/Brother-in-law/Nephew/Niece/Employer-Employee

Applicant 5

Name

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

Waistline (inch) Date of Birth D D M M Y Y Y Y Mobile number

Please tick if not Indian Passport Number

Relationship to Proposer (Please tick option): Self/Spouse/Son/Daughter-in-law/Daughter/Son-in-law/Father/Mother/Father-in-law/Mother-in-law/Grandfather/Grandmother/Grandson/Granddaughter/Brother/Sister/Sister-in-law/Brother-in-law/Nephew/Niece/Employer-Employee

Applicant 6

Name

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

Waistline (inch) Date of Birth D D M M Y Y Y Y Mobile number

Please tick if not Indian Passport Number

Relationship to Proposer (Please tick option): Self/Spouse/Son/Daughter-in-law/Daughter/Son-in-law/Father/Mother/Father-in-law/Mother-in-law/Grandfather/Grandmother/Grandson/Granddaughter/Brother/Sister/Sister-in-law/Brother-in-law/Nephew/Niece/Employer-Employee

3. Coverage Selection:

Are you applying for portability: ☐ Yes ☐ No (If ''Yes", please fill the separate portability form also).

Please tick the relevant boxes:

Base coverage:

Policy type: ☐ Individual ☐ Family Floater ☐ Family First **Plan type:** ☐ Silver ☐ Gold ☐ Platinum

Premium payment mode: ☐ Single

Number of lives to be covered: Adults ☐☐ Children ☐☐

Base Sum Insured ☐☐☐☐☐☐☐☐

*Floater Sum Insured in case of Family First policy type will be 'Number of members (value to be considered as 10 for more than 6 members) * Base Sum Insured * Multiplier factor (1.5 for 2 member policy & 1 for others)'*

Room rent opted (Applicable for Family First silver variant only)

☐ Rs 3,000 per day or Shared Room; whichever is lower

☐ Rs 5,000 per day or Single Private Room; whichever is lower

Policy coverage:

☐ Zone 1: All India coverage

☐ Zone 2: All India coverage with co-payment applicable for Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata & Gujarat State

(Note - If you select Zone 2, then 20% co-payment will apply for treatment in Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata & Gujarat State.)

Policy term: ☐ 1 Year ☐ 2 Years ☐ 3 Years

Optional Coverage:						
	Please tick to opt					
1. Enhanced Loyalty Addition	☐ Yes ☐ No					
2. Hospital Cash	☐ Yes ☐ No					
3. Enhanced Geographical Scope for International coverage, Maternity Benefit and Specified Illness (applicable for platinum plan only)	☐ Yes ☐ No					
4. Double your Sum Insured for 'international coverage' (applicable for platinum plan only)	☐ Yes ☐ No					
	Applicant Number					
	1	**2**	**3**	**4**	**5**	**6**
5. Please tick if opting for 'Personal Accident cover' (This option is available only to Applicants of age 18 years or above).						
- If 'Personal Accident cover' is opted, please tick if the Applicant is involved in a job or an occupation related to working as a staff in an aircraft or a sea going vessel, underground mining or tunneling, armed forces or security forces, participating in any adventure sports (including motor speed contests).						
6. Please tick if opting for 'Critical Illness cover' (This option is available only to Applicants of age 18 years or above) Coverage amount opted is ☐☐☐☐☐☐☐☐☐☐☐☐						
- If 'Critical Illness cover' is opted, please tick if the Applicant have been diagnosed or undergoing treatment for any chronic condition which impacts heart, brain, lungs, kidneys, liver, pancreas, spleen, intestines, blood vessels, bones/joints or any other body organ other than minor medical illness.						
7. Please tick if opting for 'Health Coach' (This option is available only to Applicants of age 18 years or above) - If 'Health Coach' is opted, providing Applicant's mobile number under Section 2 is mandatory.						
☐ In the event of opting for 'Health Coach' coverage, I agree that the Company may provide Applicant's relevant details to the service provider to contact the Applicant to provide the services under the benefit. I further agree and consent that tracking details on the mobile application are required by the Company and the service provider. I declare and consent through my own free will and without any duress that the Company and its authorized service provider may access and record these details on a periodic basis.						

4. 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 for all other applicant(s) shall be the proposer himself/herself.

Nominee Name	Date of Birth	Relationship with the Proposer	Address and contact details of Nominee	Appointee Name (if nominee is less than 18 years of age)

5. Medical and Habits 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 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. Have you ever been hospitalized for more than 5 days, undergone/advised to undergo any surgical procedures, or taken any medication/had any symptoms for more than 14 days? Medication is including but not limited to inhalers, injections, oral drugs and topical applications.	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ii. Have you ever had adverse findings to any diagnostic tests or investigations such as 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. Do you have diabetes or high blood pressure?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
iv. Do you have any pre-existing diseases/conditions?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
v. Have you 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. Have you ever been diagnosed or treated for any mental/psychiatric disorders?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
vii. Are you currently pregnant and/or have had any complications in the current or earlier pregnancies or undergone/undergoing any form of fertility treatment? (applicable to females between the age of 18 to 50 years)	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							

6. Past Proposals

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?	Applicant Number											
	1		2		3		4		5		6	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

7. Authorization for Electronic Policy Fulfillment and Service Communications

Would you 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? ☐ Yes ☐ No

8. 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.

Date ☐☐☐☐☐☐☐☐ Place _____ Signature of the Proposer ☐

9. 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 Witness

Signature of the Witness ☐

Signature of the Proposer ☐

10. Proposer Declaration

(Certification where for any reason, the proposal and other connected papers are not filled in by the prospect.)
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.

Signature of the Proposer

11. Premium Details (for office use only)

Premium payment option ☐ Cheque ☐ Demand Draft ☐ Credit card ☐ Cash

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

Intermediary Code

Intermediary Name

Proposal received on: D D M M Y Y Y Y

Customer ID:

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

12. Additional Details for Bancassurance Channel Only (For Office Use Only)

Branch Code SP Code

RM/LG code

Customer account number

13. Insurance Intermediary Report (for office use only)

1. Are you related to the Proposer? Yes/No; If yes, nature of relationship?
2. For how long have you known the Proposer? Years Months
3. Are you satisfied with the identity of the Proposer? ☐ Yes ☐ No
4. Does the Proposer or any applicant have any physical deformity/defect or mental retardation? ☐ Yes ☐ No
5. Have you explained the conditions for renewability, exclusions of the Policy and has the Proposer personally completed the health declaration? ☐ Yes ☐ No
6. Do you recommend acceptance of this proposal form considering all the factors including moral hazard? ☐ Yes ☐ No
7. Have you dispassionately advised the Proposer and provided all material information to enable the Proposer to decide in the best cover that would be in his/her interest? ☐ Yes ☐ No

Date D D M M Y Y Y Y

Signature of the Insurance Intermediary

14. 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.

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Key Feature Document (KFD) – Health Premia

Niva Bupa is dedicated to being fair and transparent with its customers. This document summarizes the key features of your Policy, however it does not replace your Policy contract and we encourage you to read all the details of your Policy before you conclude the purchase of this product.

'Health Premia' provides you with a comprehensive range of inpatient benefits. Further, there are some additional benefits under the gold and platinum plans (which are mentioned below) as well as optional benefits for you to buy if you wish to enhance your cover.

The following base benefits are provided, subject to some limits and exclusions as specified in your Policy:

Base benefits under silver, gold and platinum plans

- Inpatient care at a hospital, including room rent (as per your opted plan) and ICU charges
- Pre and post hospitalization expenses for 90 and180 days respectively
- Day Care Treatments
- Domiciliary Hospitalization
- Alternative Treatments
- Living Organ Donor Transplant
- Emergency Ambulance
- Unlimited tele/online medical consultations
- Maternity Benefit is covered for up to 2 pregnancies or terminations post waiting period of 24 months; under the platinum plan, covered worldwide except USA & Canada.
- New born baby (including vaccinations of the new born baby)
- Health Check-up, starting from Day 1
- Refill Benefit up to Base Sum Insured is available only under Individual and Family Floater Plans. Family First plan does not have Refill benefit.
- Automatic free of charge extension for 1 year if the Policyholder (who should also be an Insured Person) dies or is diagnosed or undergoes treatment for the first time, with any of the Specified Illness during the Policy (not available for individual cover)
- Pharmacy and Diagnostic booking services
- Loyalty Additions: Post completion of a Policy Year, addition of 10% of the expiring base Sum Insured, subject to a maximum of 100% of the base Sum Insured
- Emergency Assistance Services for Medical referral, Emergency medical evacuation, Medical repatriation, Compassionate visit, Care and/or transportation of minor children & Return of mortal remains
- Expenses incurred for Hospitalization (including Day Care Treatment) due to condition caused by or associated with HIV/AIDS are covered under the policy subject to sub-limit as specified in the Policy.
- Expenses incurred for inpatient treatment for mental illness are covered under the policy subject to sub-limit for specific conditions as specified in the Policy.
- Modern Treatments covered, subject to limits

Additional base benefits under the gold and platinum plans

- LASER surgery is covered subject to sub-limit as specified in the Policy.
- International coverage outside India except USA & Canada for Emergency Hospitalization, Emergency Medical Evacuation, OPD cover (with a co-payment of 20%), Compassionate visit, Loss of Passport, Care and/or transportation of minor children, Loss of checked-in baggage, Return of mortal remains, Trip Cancellation & Interruption, Trip Delay, Delay of Checked-in Baggage, Medical Referral and Medical Repatriation; subject to sub-limits as specified in the Policy.
  - One Single trip for maximum 15 days per person is covered under Gold plan.
  - Annual multi trips are covered under Platinum plan for a maximum of 45 days covered in a single trip.

Further additional base benefits under the platinum plan

- Second Medical Opinion (worldwide) on the diagnosis of specified illness or planned surgery
- Child Care Benefits (Vaccinations for children up to 12 years including one consultation for nutrition and growth during the visit for vaccination)
- Specified Illness Cover outside India except USA & Canada
- OPD Treatment and Diagnostic Services with no co-payment

The following optional benefits are provided subject to some limits and exclusions as specified in your Policy:

- Personal Accident coverage against accidental death, permanent total and partial disability
- Critical illness coverage for 20 major critical illnesses
- Daily hospital cash benefit in case of hospitalization
- Enhanced Loyalty Addition of 20% of the expiring base Sum Insured at renewal, subject to a maximum of 200% of the base Sum Insured.
- International coverage extension – Below options are available for enhancing international coverage:
  - Additional trips are available on single trip basis; from 1 day to 30 days under Gold plan only
  - Sum Insured for 'international coverage' benefit can be doubled
- Enhanced Geographical Scope for extending cover to USA & Canada for Maternity Benefit and Specified Illness under platinum plan and international coverage base benefit
- Personalized Health Coach for insured aged 18 years & above for any 90 days per Policy Year

Please note that an additional annual premium is charged for the optional benefits

Note that waiting periods are applicable as per the Policy:

- Pre-existing Disease waiting period of 24 months since inception of the Policy and subject to continuous renewal.
- Initial Waiting Period of 30 days unless the treatment needed is the result of an Accident.
- Specific Waiting Period of 12 months for some listed illnesses, unless the condition is directly caused by Cancer (covered after Initial Waiting Period of 30 days) or an Accident (covered from day 1).
- The following benefits will have a waiting period of 36 months since inception of the Policy and subject to continuous renewal:
  - Mental disorder treatment
  - LASER surgery cover
- For HIV/AIDS cover, there will be a waiting period of 48 months since inception of the Policy and subject to continuous renewal.
- For Critical Illness cover, a 90 days initial waiting period along with the Pre-existing Disease waiting period of 4 years and Survival Period exclusion of 30 days will apply for all conditions.

Note that standards exclusions are applicable as set out in the Policy contract. In addition, based on the underwriting results, some specific exclusions or personal waiting period might also apply to your Policy.

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Other key features of your Policy are as follows:

- Individual or family floater cover (up to 4 children) or Family First cover (up to 19 relationships),with any addition or deletion of member(s) in the Policy being done only at the time of renewal.
- Sum Insured (in case of family first): Your plan offers both individual Sum Insured and floater Sum Insured in the same policy. For example, a Family First policy is chosen for 6 members (say self, spouse, parents and two children) with a Sum Insured of 5 Lacs + 30 Lacs. Any member can claim for up to 5 Lacs from his/her Individual Sum Insured. Any claim exceeding 5 Lacs will get covered through floater Sum Insured of 30 Lacs. Hence, an individual member can claim up to 35 Lacs in a single claim, however the floater Sum Insured can be used only up to 30 Lacs for all members together during the policy year. On a cumulative basis in a policy year, total claims can be made is 60Lacs (i.e. 6 members*5 Lacs each + 30 Lacs floater Sum Insured).
- Lifelong renewability of your Policy subject to your confirmation and timely payment of the due premium.
- Your renewal premium will increase as your age increases but will not alter based on your claim experience. Renewal premium rates for the product may be revised in future subject to IRDAI approval and in accordance with the IRDAI's rules and regulations as applicable from time to time.
- In case your proposal is declined for issuance, you will bear 100% of the cost incurred towards the cost of Pre Policy Medical Check-up (PPMC).
- Free look provision: If you do not agree to the terms and conditions of the policy, you may cancel the policy, stating your reasons within 15 days of receipt of the policy document provided no claims have been made under any benefits. The premium shall be refunded after deducting charges for medical check-up, stamp duty and proportionate risk premium for the cover period. The free look provision is not applicable at the time of renewal of the policy.

NOTES:

- Premium: kindly deposit the premium amount through a secure mode of payment in the name of Max Bupa Health Insurance Company Limited.
- In case of any query or claim, please contact our Customer Helpline No: 1860-500-8888

_____ I hereby consent to and authorize the Company to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of Company from time to time.

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. This will ensure continuity of your policy benefits.

___I want to opt for the ACH/SI renewal option.

Date: _____ Signature of Proposer: _____

Place: _____ Name of Proposer: _____

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

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 for any Policy sought 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.

Signature of the receiver and office seal