MediPlus

Proposal Form

TATA AIG INSURANCE
WITH YOU ALWAYS

Application Number _____

This is an application for Insurance. Every Information this application seeks is important. Please read all questions and answer them carefully. You must provide complete and correct information. Incomplete/incorrect/partially correct information may lead to cancellation of proposal and policy even if it is issued. It is not obligatory for us to accept any risk or issue policy to anyone. Regulations mandate that the coverage can incept only after we have received the full amount of premium and have explicitly accepted the risk. We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). Please note that We will issue Policy only after getting Your consent in case of risk loading. If We accept a proposal for insurance, it shall be subject to the Policy terms and conditions and We shall have no liability to make any payment under the Policy if proposal is not accepted by us or you do not accept the terms of counter offer or premium is not received by Us in full and in time, or is not realised, or non-fulfillments of Pre Policy Checkup and/or additional information requested by us.
If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 7 days subject to deduction of the Pre Policy Check up charges, as applicable. In case of counter offer you need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 15 days, we shall cancel application and refund the premium paid without interest within next 7 days subject to deduction of the Pre Policy Check up charges, as applicable.
Please fill-up this form in CAPITAL LETTERS and attach a passport sized photograph for Yourself and each proposed Insured person and write the name of the person above the photograph.

Proposer Details

Proposer ☐ Mr. ☐ Mrs. ☐ Ms. — First Name | Middle Name | Surname

Address (We will send your policy and all other important documents here)

City/Town _____ District _____

State _____ PIN _____

Phone (O) _____ Mobile _____

E-mail _____

Nationality _____ Marital Status: Single ☐ Married ☐ Annual Income _____

Profession: ☐ Salaried ☐ Self-Employed ☐ Others ☐ Details _____

ID Proof Type: ☐ PAN ☐ Passport ☐ Driving License ☐ Voter's Card Others _____

ID Proof No: _____

Plan Details

Sum Insured: Rs. 500,000 Deductible: ☐ Rs. 100,000 ☐ Rs. 200,000 ☐ Rs. 300,000 ☐ Rs. 400,000 ☐ Rs. 500,000

Proposed Policy Period: From D D M M Y Y Y Y To D D M M Y Y Y Y **Policy Tenure:** ☐ 1 Year ☐ 2 Years (Get 7.5% Discount in premium on selecting 2 year term)

Proposed Insured(s) Details

Sr. No.	Name of the Insured person	Height (cms)	Weight (kg)	Relationship to Policyholder	Gender* (M/F)	Date of Birth (DD/MM/YYYY)	Occupation	Deductible
1		C M S	K G S		M F	D D M M Y Y Y Y		
2		C M S	K G S		M F	D D M M Y Y Y Y		
3		C M S	K G S		M F	D D M M Y Y Y Y		
4		C M S	K G S		M F	D D M M Y Y Y Y		
5		C M S	K G S		M F	D D M M Y Y Y Y		
6		C M S	K G S		M F	D D M M Y Y Y Y		
7		C M S	K G S		M F	D D M M Y Y Y Y		

*Gender Code-M (Male), F (Female)

Please paste the photographs in sequence [Insured Person 1, Insured Person 2, Insured Person 3, Insured Person 4, Insured Person 5, Insured Person 6, Insured Person 7] as specified in section 3 of details of persons proposed to be insured

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7

Nominee Details

In the event of the death of the Proposer any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. Nominee should be an immediate relative of the insured.

Nominee Name	Date of Birth	Relationship	Address of Nominee

*If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship	Address of the Appointee

MediPlus UIN : IRDA/NL-HLT/TAGI/P-H/V.I/97/13-14

Existing / Previous Insurer Details

Is the proposer or any of the persons proposed, already Insured under a plan with Tata-AIG General Insurance Company Limited or any other insurer or is a proposal pending for Policy issuance? If yes, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.) Since when are you continuously insured:
Do you want Us to consider these details for portability* ? Yes ☐ No ☐

Policy No. / Application No.	Insurer	Period of Insurance		Sum Insured (Rs)	Claims lodged during the preceding years
		From	To		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		

* Please note that continuity of benefits shall NOT be considered if the details are not provided. You need to approach at least 45 days prior to your expiry date to avoid any break in coverage.

Medical And Lifestyle Information

Important : You must answer the following questions truthfully. Not doing so affects your coverage in case of a Claim
Medical History: Please answer the below mentioned questions in Yes (Y) / No (N)

Section A: Have any of the persons proposed to be insured ever suffered from/currently suffering from any of the following :		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7
I.	Hypertension, chest pain, Ischemic heart disease or any other cardiac disorder	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
Ii.	Tuberculosis, asthma, bronchitis or any other lung/respiratory disorder	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
Iii.	Ulcer(stomach/duodenal), hepatitis, cirrhosis or any other digestive or liver/ gallbladder disorder	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
Iv.	Renal failure, calculus or any other kidney/urinary tract or prostate disorder	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
V.	Dizziness, stroke, epilepsy, paralysis or other brain/ nervous system disorder	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
vi.	Diabetes, thyroid disorder or any other endocrine disorder	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
vii.	Tumor-benign or malignant, any ulcer/growth/cyst	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
viii.	Arthritis, spondylosis or any other disorder of the muscle/bone/joint	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
ix.	Diseases of the nose/ear/throat/teeth/ eye (please mention dioptres)	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
x.	HIV/AIDS or sexually transmitted diseases or any immune system disorder	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
xi.	Anaemia, leukaemia or any other blood lymphatic system disorder	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
xii.	Psychiatric/mental illnesses or sleep disorder	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
xiii.	DUB, fibroid, cyst/fibroadenoma or any other gynecological/breast disorder	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N

Section B: Have any of the persons proposed to be insured:		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7
xiv.	Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
xv.	Been under any regular medication (self/ prescribed)	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
xvi.	Undertaken any lab/blood tests, imaging tests viz. scans / MRI in the last 5 years	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
xvii.	Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
xviii.	Suffered from any other disease/illness/accident/injury	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
xix.	Is any of the insured persons pregnant? If yes please mention the expected date of delivery	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N
xx.	Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N

Section C: Name and details of Illness/ Medicine/Test/ Surgery/Diopter grade (for questions answered as Yes in Section A & B)	Diagnosis date	Date of last consultation	Treatment in/ outpatient	Doctor/Hospital Name and Phone No.
Insured 1				
Insured 2				
Insured 3				
Insured 4				
Insured 5				
Insured 6				
Insured 7				

Section D: Name, address, qualification and contact details of the family doctor, if any

Name:

Qualification:

Address:

Pin Code

Mobile No: Phone No:

Email ID:

Section E: Does any person proposed to be insured smoke or consume gutkha/pan masala or alcohol. If yes please indicate the name and quantity per week.	Alcohol	Smoke	Pan Masala	Others
Insured 1				
Insured 2				
Insured 3				
Insured 4				
Insured 5				
Insured 6				
Insured 7				

Section F: In respect of any of the persons proposed to be insured:	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7
Has any application for life, health or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N	☐Y/☐N

MediPlus UIN : IRDA/NL-HLT/TAGI/P-H/V.I/97/13-14

Premium Payment Details (Please tick on the preferred option)

Name of the Premium Payer :

☐ Cash ☐ Cheque DD No. Date D D M M Y Y Y Y Amount (in Rs) Bank & Branch _____

☐ Card Type _____ No :

Sources of funds : (Please tick where applicable)

☐ Salary ☐ Business ☐ Other _____

Please make a Crossed Cheque/DD/Pay Order in favour of 'Tata AIG General Insurance Company Limited' only.

Bank Details

As per the Regulatory requirements ,we can effect payment of refund / claims only through Electronic Clearing System (ECS) / National Electronic Funds Transfer (NEFT) / Real Time Gross Settlement (RTGS) / Interbank Mobile Payment Service (IMPS). For this purpose please submit the following details of the insured's bank account#

Name of the Account Holder:

Name of the Bank Branch:

Type of Account : ☐ SB Account ☐ Current Account Others (please specify)

Account Number :

IFSC Code of Bank :

If the premium cheque is not paid from the above mentioned account then a cancelled cheque leaf of the above mentioned account is to be attached. #mandatory if annualized premium is more than Rs.25,000

I. Section 41 of Insurance Act 1938 (Prohibition of Rebates) :

(1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take 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 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 prospectus or tables of the insurer.

(2) Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to ten lakh rupees.

II. AML guidelines :

(1) I/we hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act, 2002.

(2) I understand that the Company has the right to call for documents to establish sources of funds.

(3) The insurance company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statues, directly or indirectly governing the prevention of money laundering in India.

- **Nationality :** Indian ☐ Non-Indian ☐ If Non-Indian, please specify Country : _____
- **Type of Organization**

Corporations ☐ Governments ☐ Non Governmental Organizations ☐ Society ☐

Trust ☐ Partnership ☐ International Organization ☐ Cooperatives ☐ Section 25 Company ☐

PAN Card No. in the absence of PAN Card, please give details of any other authorized photo identification card.

Card Type _____ Number :

Sources of funds (please where applicable) Salary ☐ Business ☐ Other (Please specify) _____

Additional Information

(If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

General Exclusions

I have carefully read and understood the below mentioned exclusions.

Signature of the proposer _____

The following is an outline of the general exclusions under the policy. For more details on the exclusions and the waiting periods please refer to the policy wordings before purchasing this policy.

30 days waiting period in the first year and is not applicable in subsequent renewals; 2 years waiting period for the specified illnesses/ surgeries. 4 years waiting period for Pre-existing conditions.

War or any act of war, invasion, act of foreign enemy, war like operations, nuclear weapons/materials radiation of any kind; committing or attempting to commit a breach of law with criminal intent, or intentional self injury or attempted suicide while sane or insane; participation or involvement in naval, military or air force operation or any hazardous or dangerous or adventurous activities including but not limited to racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing; abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services or supplies; treatment of obesity or any weight control program; psychiatric, mental disorders, Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), congenital internal or external diseases, genetic disorders, stem cell implantation or surgery or growth hormone therapy; sleep apnoea; venereal disease, sexually transmitted disease, "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus)' sterility / infertility treatment of any type; pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy; treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, muscle stimulation by any means except for treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities; dental treatment unless requiring hospitalization; treatment of nasal concha resection, circumcisions unless necessitated by illness or injury and forming part of treatment, laser treatment for correction of eye due to refractive error, aesthetic or change-of-life treatments; plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment for reconstruction following an Accident, Cancer or Burns; experimental, investigational or unproven treatment devices and pharmacological regimens; measures primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the diagnosis and treatment; convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care; all preventive care, vaccination including inoculation and immunizations (except in case of post- bite treatment); any non allopathic treatment; enteral feedings and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim; charges related to a Hospital stay not expressively mentioned as being covered, items of personal comfort and convenience, vitamins and tonics; treatments rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who shares the same residence as an Insured Person or who is a member of an Insured Person's family; the provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products; any treatment or part of treatment that is not of a reasonable cost, not medically necessary; drugs or treatment which are not supported by a prescription; artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment. Any specific timebound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured, as per Our underwriting guidelines , any non medical exclusions as per Annexure II of the policy document. For complete list of detailed exclusions, please refer policy wordings.

Please cut here

MediPlus UIN : IRDA/NL-HLT/TAGI/P-H/V.I/97/13-14

DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- ☐ I/ We 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/We am/ are authorized to propose on behalf of these other persons.
- ☐ I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved underwriting policy of the Insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- ☐ I/ We further declare that I/We 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/We declare and consent to the company seeking medical information from any hospital who at anytime has attended on the life to be insured/ proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/ proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- ☐ I/ We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory Authority.

Signature of the Proposer: _____

Place: _____ Date: D D M M Y Y Y Y

Vernacular Declaration

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent/ employee of the company).

Name of the Proposer: _____

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:

Signature of the Proposer _____ Signature of the witness _____

Date: D D M M Y Y Y Y Name of the witness: _____

Place: _____

Agent Declaration

I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized 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, the Company shall have the right to vary the benefits which may be payable 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.

License No. (Advisor/Corporate Agent/Broker/Relationship Officer) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Place: _____

Date: D D M M Y Y Y Y Signature of Agent: _____

Check List

Please check the following documents are attached along with the proposal form

1. ID Proof: Passport/ PAN Card/ Voter ID/ Driving License/ Letter from a recognized public authority
2. Proof of residence: Telephone Bill/Bank Account Statement/Letter from any recognized public authority/ Electricity Bill/ Ration Card
3. Age Proof: Proof of Age
4. Renewal Notice with claim details
5. Certification of previous insurer for previous claim details
6. Photocopies of all previous policies and endorsements

For Office Use Only

Tata-AIG Office Code: _____ **Advisor Code and Name:** _____

Branch Receipt Date: _____ **Channel Type:** _____

Business Type: Urban/ Rural/ Social _____

Disclaimer: Insurance is the subject matter of the solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale.

MediPlus UIN : IRDA/NL-HLT/TAGI/P-H/V.I/97/13-14

Tata AIG General Insurance Company Limited

Registered Office: Peninsula Business Park, Tower A, 15th Floor, G.K. Marg, Lower Parel, Mumbai – 400013

24X7 Toll Free No: 1800 266 7780 or 1800 22 9966 (For Senior Citizens) Fax: 022 6693 8170 Email: customersupport@tata-aig.com Website: www.tataaiginsurance.in

IRDAI Registration No: 108 CIN:U85110MH2000PLC128425

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ACKNOWLEDGEMENT

Application Number: _____ Date: _____

Name of the Proposer _____

We acknowledge with thanks the receipt of your application and amount by cash/cheque/Demand Draft/others _____ _____ of amount of Rs. _____.

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 terms and conditions and we shall have no liability to make any payment if proposal is not accepted by us or you do not accept the terms of counter offer or premium is not received by us in full and in time, or is not realised, or non-fulfillments of Pre Policy Checkup and/or additional information requested by us. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 7 days subject to deduction of the Pre Policy Check up charges, as applicable. In case of counter offer you need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 15 days, we shall cancel application and refund the premium paid without interest within next 7 days subject to deduction of the Pre Policy Check up charges, as applicable.

Place: _____ Signature of the receiver and office seal _____

Date ☐☐☐☐☐☐☐☐