Health Insurance
Aditya Birla Health Insurance Co. Limited

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

Group Activ Secure - Enrollment Form

For Internal Use Only

Partner Channel: _____ Branch/Location: _____ State: _____

ABHI Sales Person: _____ Loan Account No. (LAN) _____

Please Note:
1. To be filled and signed by Applicant
2. This Application shall form the basis of cover

Customer Information (to be filled in capital)

1. Customer ID _____
2. Applicant's Full Name (Mr./Mrs./Ms.)

_____

3. Applicant's Address

_____

_____

City _____Pin Code _____ State_____

Phone No. +91 - _____

Email Address _____

4. Gender ☐ Female ☐ Male
5. Date of Birth _____
6. Pan No. _____ 7. UID Aadhaar No. _____
8. Occupation ☐ Salaried ☐ Self-Employed

1. Customer ID _____
2. Co-Applicant's Full Name (Mr./Mrs./Ms.)

_____

3. Co-Applicant's Address

_____

_____

City _____Pin Code _____ State_____

Phone No. +91 - _____

Email Address _____

4. Gender ☐ Female ☐ Male
5. Date of Birth _____
6. Pan No. _____ 7. UID Aadhaar No. _____
8. Occupation ☐ Salaried ☐ Self-Employed

Loan Details

1. Disbursal Date _____
2. Loan Amount _____ 3. Loan Tenure _____ Years
4. Type of Loan to be Insured ☐ HL ☐ LAP ☐ Gold ☐ SME ☐ BL ☐ PL ☐ Affordable housing

Insurance Details

1. Personal Accident Sum Assured - _____
2. Personal Accident Cover Tenure - _____
3. Critical Illness Sum Assured - _____
4. Critical Illness Cover Tenure - _____

1. Personal Accident Sum Assured - _____
2. Personal Accident Cover Tenure - _____
3. Critical Illness Sum Assured - _____
4. Critical Illness Cover Tenure - _____

Premium / Cheque Details

1. Total premium amount _____ 2. Cheque amount _____ 3. Cheque no. _____
4. Cheque date _____ 5. Bank name/Location _____

Nominee Details (To be filled in capital)

1. Nominee Name _____
2. Gender ☐ Female ☐ Male
3. Date of Birth (DD/MM/YYYY)_____
4. Relationship with Applicant _____

1. Nominee Name _____
2. Gender ☐ Female ☐ Male
3. Date of Birth (DD/MM/YYYY)_____
4. Relationship with Co-Applicant _____

Table of Benefits

Coverage	Details
Personal Accident	
a) Personal Accidental Death	100% of Sum Assured
b) Permanent Total Disability	100% of Sum Assured
c) Education Fund for Children	In case of Accidental Death or Permanent Total Disablement due to accident , we will pay lump sum amount up to 2% of sum insured or Rs 200,000/- (*irrespective of number of children) whichever is less to the dependent child(ren) of the Insured. This allowance will be payable to the dependent children of the Insured towards their educational expenses, provided that the children are pursuing their education at the time of claim under this Section.
d) Loss of Job Cover	5% of Sum Assured or Rs 75,000/- whichever is higher, upto a maximum of 75000/-.
Critical Illness	
a) Critical Illness	100% of Sum Assured

Health Declaration

Has the applicant been hospitalized for any treatment of any illness/disease or injury during any time in the past? (If yes, please select the disease/injury as mentioned below). If others please specify along with Year of the occurrence.

	Applicant	Co-Applicant
1. Diabetes Melitus or impaired glucose tolerance	☐ Yes ☐ No	☐ Yes ☐ No
2. Multiple Sclerosis	☐ Yes ☐ No	☐ Yes ☐ No
3. Hypertension/Heart Disease(s)	☐ Yes ☐ No	☐ Yes ☐ No
4. Blindness	☐ Yes ☐ No	☐ Yes ☐ No
5. Respiratory disorder(s)	☐ Yes ☐ No	☐ Yes ☐ No
6. Congenital Disease(s)/Genetic disorders/Inflammatory bowel disease (Crohn's disease Ulcerative Colitis)	☐ Yes ☐ No	☐ Yes ☐ No
7. HIV/AIDS/STD	☐ Yes ☐ No	☐ Yes ☐ No
8. Cirrhosis (Alcoholic/Non Alcoholic)/Liver Disease/Hepatitis	☐ Yes ☐ No	☐ Yes ☐ No
9. Renal Transplant/Congenital disorders of renal failure/chronic renal disorder, ESRD, Proteinuria/Kidney Disease(s)	☐ Yes ☐ No	☐ Yes ☐ No
10. Cancer/Tumor	☐ Yes ☐ No	☐ Yes ☐ No
11. Mental Retardation/Psychiatric disorder	☐ Yes ☐ No	☐ Yes ☐ No
12. Arthiritis/Joint Pain	☐ Yes ☐ No	☐ Yes ☐ No
13. Obese/Dyslipidemic	☐ Yes ☐ No	☐ Yes ☐ No
14. Coma/Paralysis/Stroke/Epilepsy/Paraplegic/Hemiplagic/Quadriplegic Individuals	☐ Yes ☐ No	☐ Yes ☐ No
15. Injury/Persons with disability	☐ Yes ☐ No	☐ Yes ☐ No
16. Others (Please specify the name of disease/Injury)	☐ Yes ☐ No	☐ Yes ☐ No

If others please specify along with Year of the occurrence.

Declaration & Warranty by the Applicant

I. I have read and understood the brochure, prospectus, sales literature & policy wordings and confirm to abide by the same.
II. I agree that this application is part of Group Policy issued to Master Policyholder for covering their secured/unsecured loan customer and renewal thereafter.
III. I agree that the cover shall be voidable at the option of the company, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the application form/personal statement, declaration and connected documents or any material information has been withheld by me or anyone acting on my our behalf to obtain any benefit under this cover.
IV. I understand that the information provided by me will form the basis of the insurance cover and is subject to the Board approved underwriting policy of the insurance company and will come into force only after full receipt of premium chargeable.
V. I further consent and authorize Aditya Birla Health Insurance Co. Limited and/or any of their authorized representatives to seek medical information from any hospital / Medical Practitioner / Insurer / any of the related entity that I have attended or may attend in future concerning and disease / illness / injury.
VI. I understand and agree that the cover tenure will be less or equivalent to loan tenure. Subject to same, cover is valid only till I am / we are Loan Customer
VII. 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 claim settlement and with any governmental and/or regulatory authority.

VIII. I understand and agree that the insurance coverage shall commence not earlier than the date of disbursal of loan as referred overleaf or after full premium is received by Aditya Birla Health Insurance (hereinafter referred to as the "Company") whichever is later subject to underwriting approval by the company. Receipt of application form by the company shall not be construed as an acceptance of my application. The company in its sole discretion reserves the right to accept or reject any application without any assigning any reason thereof.

IX. I understand and agree that no benefit under the policy shall be payable for any critical illness or surgical procedure which results due to any pre-existing disease or illness or symptoms or which is diagnosed within 90 days of cover period.

X. I hereby declare that I would submit 2 medical examinations, before the nominated doctor of the company, or undergo diagnostic or other medical test, as suggested by the company for its underwriting or claim.

XI. I also confirm and declare that I am the applicant of the loan whose details have been mentioned in the application form.

XII. I have read and understood that the cover is available for loan tenure or the full prepayment of the loan whichever is earlier but not beyond the end date of the period of insurance.

XIII. I understand and agree to the following: - a. in case of more than one applicant under the same loan Account No. then the sum insured in aggregate for all the loan applicant(s) shall not exceed the loan sanctioned amount and the sum insured shall be equal for all applicants. b. The company's total liability for an individual in aggregate shall not exceed 1 crore, subject to sum insured irrespective of the number of covers under which he or she is covered. c. Sum insured cannot exceed loan sanction amount. d. If sum insured is not given, disbursed amount will be considered as sum insured.

XIV. In case of any claim made under the Cover, No premium shall be refunded on cancellation of the Cover.

XVI. I consent to provide a valid age proof and identity proof at the time of claims or any other time when required by the Company.

XVII. I/We consent to receive information from the company through physical, electronic or telecommunication means from time to time.

_____ _____

Applicant's Signature **Co-Applicant's Signature**

Date _____ Date _____

Place _____ Place _____

Applicant's Declaration:

"I _____, s/o D/o W/o _____

holding loan from_____with LAN (Loan Account No)_____ have obtained _____ cover/sum assured from Aditya Birla Health Insurance Co. Limited and am fully aware of the coverage and the terms and conditions.

In the event of claims as per the terms and conditions of the cover i hereby express my freewill and consent to remit the claim amount to the financier and i do not have any objection for the same and balance if any to be paid to Myself/ Legal heirs as per the terms and condition of the cover.

Date _____ _____

Place _____ **Applicant's Signature**

Co-Applicant's Declaration:

"I _____, S/o D/o W/o _____

_____holding loan account from _____

With the loan account number _____ with _____.x

I have obtained _____ cover from Aditya Birla Health Insurance Company Limited and I am fully aware of the coverage and terms and conditions.

In the event of claims as per the terms and conditions of the cover, I hereby express my free will and consent to remit the claim amount to the financier and I do not have any objection for the same and balance if any to be paid to myself / Legal heirs as per the terms and conditions of the cover.

Date _____ _____

Place _____ **Co-Applicant's Signature**

Vernacular Declaration:

I hereby declare that I have fully explained the contents of the proposal form and all other documents incidental to availing the health insurance from Aditya Birla Health Insurance Company to the Proposer in the language understood by him / her. The same have been fully understood by him / her and the replies have been recorded as per the information provided by the Proposer. Replies have been read out to, fully understood and confirmed by the Proposer.

Declarant Name: _____ **Declarant Signature:** _____

Date: _____

Member Name: _____ **Member Signature / Thumb impression:** _____

Date: _____ Place: _____

Aditya Birla Health Insurance Co. Limited.
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