Health Insurance
Aditya Birla Health Insurance Co. Limited

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

Arogya Sanjeevani Policy, Aditya Birla Health Insurance Co. Limited - Proposal Form

1. Please select the appropriate options and fill the form in BLOCK LETTERS.
2. All details marked with (*) are mandatory.
3. Please disclose all facts and mention each information that may affect our decision to issue a policy or its price, terms, conditions, exclusions, truthfully and accurately as incorrect information may lead to policy cancellation/ claim rejection. The Policy shall become void at our discretion, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure of any material fact, particularly in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the proposer or any one acting on his behalf. If You are in any doubt, please seek the advice of your insurance advisor.
4. The policy would be incepted only after complete premium including loading premium (if applicable) is submitted by You & there may be break in period (during which You are not covered) in case of Portability proposal. Hence is it advisable to extend your porting policy with existing insurer with short period basis until the proposal is accepted & issued by us in case of portability request.
5. The Proposer must authenticate each cancellation/ alteration in this form

Application No-Barcoded*:

Customer ID: _____ Branch Stamp: _____ (To be filled by Branch Official)

I. Proposer Details:

Gender*: ☐ Male ☐ Female ☐ Others **Date of Birth:** D D M M Y Y Y Y

Name*:	First* Middle Last*
Correspondence Address*:	**City*:** _____ **Town (District)*:** _____ **State*:** _____ **PIN Code*:**
Contact Number*	Mobile Number* _____ Emergency/Alternate Contact No. _____ WhatsApp No, If Different From Mobile Number _____
Email Id*:	(All proposal/policy related communications will be sent on this e-mail id)
Identification Type*	☐ PAN Card ☐ Passport ☐ Driving License ☐ Voter's ID ☐ Others _____ Please mention ID Number _____
PAN	_____ (PAN No. is mandatory in case premium is > Rs 1,00,000 (irrespective of the mode of payment of premium) Or > Rs 50,000 accepted in Cash)
GST Registration Status*	☐ Consumer ☐ Registered Dealer ☐ Compounding Dealer Please specify GST Identity Number: _____ (mandatory for Registered dealer & Compounding dealer)
Annual Income*	☐ Up to 4.5 L ☐ 4.5 to 10 L ☐ 10L to 20L ☐ >20L
Educational Qualification*	Below Matric ☐ Matric ☐ Graduate ☐ Post Graduate ☐ Diploma ☐ Professional Degree ☐ Others ☐ _____
Occupation*	Government Employee ☐ Private Service ☐ Business ☐ Professional CA ☐ Doctor ☐ Lawyer ☐ Retired ☐ Housewife ☐ Others ☐ _____
Marital Status*	☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated
Nationality*	Indian ☐ Non Resident Indian ☐ Foreign National with Indian Origin ☐ Person of Indian Origin ☐ Others ☐

II. GO Green & Whatsapp Consent*:

☐ I would like to contribute in creating a healthier, greener and cleaner environment by authorizing Aditya Birla Health Insurance Co. Limited to send all my policy & service related communication to the Email ID mentioned in this application form.

☐ I choose to have hardcopy of policy documents

To serve you better we will use WhatsApp Channel to send you updates about your proposal/policy with us. You hereby give consent to and authorize Aditya Birla Health Insurance Company to send you communication via Whatsapp Channel. We respect your privacy and will ensure that promotional content is not shared through this channel ☐ Yes ☐ No

Product Name : Arogya Sanjeevani Policy, Aditya Birla Health Insurance Co. Limited, Product UIN: ADIHLIP20170V011920.

III. Product Details*:

Tenure*:	☐ 1 Year	**Cover*:** ☐ Individual	☐ Floater
Members Covered*:	☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Mother-in-law ☐ Father-in-law ☐ Child **Number of Children*:**		
Mode of Premium Payment*:	☐ Monthly Instalment ☐ Quarterly Instalment ☐ Semi Annual Instalment ☐ Annual		
Sum Insured(Rs)*:	☐ 1 Lac ☐ 1.5 Lac ☐ 2 Lac ☐ 2.5 Lac ☐ 3 Lac ☐ 3.5 Lac ☐ 4 Lac ☐ 4.5 Lac ☐ 5 Lac		

IV. Insured Details*:

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name*						
Relationship with Proposer*						
Gender*						
Date of Birth* (DD/MM/YYYY)						
Nationality*						
City of Residence*						
Sum Insured*						
Height* (cms)						
Weight* (kgs)						
Email ID*#						
Mobile Number*#						
Pan Card (Optional)						
Aadhar Card (Optional)						

(Mobile Number and Email id is mandatory for each adult insured. In case the contact number is not available, please mention the contact number of proposer)

V. Previous/ Current Insurance Details:

Do you have Previous/ Current policy for life/ health/ hospital daily cash/ critical illness / cancer/ Personal Accident insurance?* ☐ Yes ☐ No

Previous/Current Insurance Details: *	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Insurer Name						
Claim in previous policy(Yes/No)#						
Was any proposal/policy declined/ deferred / withdrawn / accepted with modified terms/ cancelled, if yes please provide details in additional information (Yes / No)						
Do You want to consider this Health policy for Portability## (Yes / No)						

#If claims in previous policy is "Yes", Please mention details of claim in 'Additional Information' section
##In case you want portability of your previous policy, kindly fill the portability form separately.

VI. Nominee Details*:

Nominee Name	Nominee relationship with Proposer	Nominee Contact Number

VII. Information On Health And Lifestyle*:

Please answer the following questions in "Yes" OR "No" with respect to all persons proposed to be insured. **Please attach discharge card / summary, all consultation papers, investigation reports, histopathology repots, disability certificate from civil surgeon if any.**

A. Have you ever been diagnosed with /advised / taken treatment or observation is suggested or undergone any investigation or consulted a doctor or undergone or advised surgery for any one or more from the following? **If YES, then please mention details in the additional information section below:**	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
* Diabetes(High blood sugar, Hypertension (High Blood Pressure), Hyperlipidemia (High Cholesterol or High Triglycerides)						
* Any form of Heart Disease including but not limited to Heart attack, Arrhythmias etc Procedures like Angiography /Angioplasty/ By Pass Surgery, valve replacement, Pacemaker implant etc. * Anaemia / Blood disorder (whether treated or not). * Asthma, Tuberculosis (TB), any Respiratory / Lung disease. * Disease of Eye including but not limited to Cataract, Glaucoma, Ear, Nose, Throat, Thyroid disorder. * Cancer, Tumour, lump, cyst, ulcer. * Disease of Kidney, Digestive tract, Liver/Gall Bladder, Pancreas, Breast, Fibroid (Uterus), Breast Lumps, Polycystic Ovary Disease (PCOD) or any other Gynaecological disease, Reproductive /Urinary system, or any past/current complications of pregnancy/ child birth including high blood pressure or diabetes etc. * Mental illness, Psychiatric/psychological disorder. * Disease of the Brain/ Spine/Nervous System, Epilepsy, * Paralysis, Polio, Joints/Arthritis/prolonged back pain, * Congenital/ Birth defect, Genetic Disease/Physical deformity/disability, * Polio, Obstructive sleep apnea (OSA), Peripheral vascular disease. i.e Blockage of Upper or lower limb artery/vein, Varicose Veins * HIV/AIDS, other Sexually Transmitted Disease or * Accidental injury or implant in body or any other medical (other than common cold & viral fever) or surgical condition or Investigation parameter has been detected to be out of range/ not normal?						
B. Are you suffering from or had suffered in past, any of below conditions? If YES then please mention Details in the additional information section below.						
Nephropathy						
Retinopathy, Neuropathy,						
Diabetic Foot						
Stroke						
Malignant Hypertension						
History of Renal Artery Stenosis						
History of Pheochromocytoma						
History of Aneurysm						
History of Peripheral Vascular Disease						
Chronic Obstructive Pulmonary Disease (COPD)						
C. Has any of the persons proposed to be insured						
a. Under any regular medication prescribed by the Doctor other than vitamin pills and tonics?						
b. Blood tests, X-Ray/USG/Scan/MRI in the last 5 years other than routine or pre-employment health check?						
c. Surgery done or advised and still pending for the surgery to be done?						
D. Do you consume any of the following substances?(if yes, please mention the quantity)						
Alcohol [30ml (Number of pegs) of hard liquor/ pints of beer/ glass of wines] **Per Week**						
Smoking (Number of Cigarette/bidi sticks) **Per Week**						
Pan Masala/Gutkha (Number of small Pouches) **Per Week**						
Any Other substance (Name & Quantity) **Per Week**						
E. Any of the insured persons is pregnant? If yes, please mention the expected Date of delivery. D D M M Y Y Y Y						

VII. Information On Health And Lifestyle*:

Additional Information: Please attach extra sheets if required

Details	Insured					
	1	2	3	4	5	6
Disease name						
Date of Diagnosis						
Last Consultation Date						
Name of Surgery (if any)						
Details of Treatment given(hospitalization/OPD, other)						
Disability %,						
Period of hospitalization (if any)						
Any Other information						

VIII. Premium Payment Details:

☐ Cash ☐ Cheque ☐ Demand Draft ☐ Pay Order ☐ Credit Card ☐ Debit Card

☐ Online ☐ IMPS/ NEFT/ RTGS ☐ E-Wallet ☐ UPI

Instrument Number	Instrument Date	Instrument Amount (₹)	Name of Premium Payer**	Relationship of Payer with Proposer	Bank Details (Bank account Number, Bank name, IFSC code)

** Income Tax benefit under section 80D of Income Tax Act, is available to the person who pays the health insurance premium by other than cash payment mode for himself and his family member (Spouse, dependent children & parent). Eligibilities under section 80D are subject to provisions of the Income Tax Act 1961, as amended from time to time.

IX. Bank Account Details:

Mandatory details required to process all payment due in relation to your Policy including refunds# (if any) and / or claims directly to your bank account.

Name as in Bank Account: _____

Bank Name: _____ Account Number: _____

IFSC Code: _____ Bank City: _____

Account Type (Current/Saving): _____

In case of payment through Debit Card, Credit Card and Online Mode of payment, the refund goes back to the same card or bank account as the case may be.

Date:_____ **Place:** _____ **Signature:** _____ _____

NACH Mandate#:

☐ I would like to avail the renewal premium payment facility by mandating ABHI to debit my premium through NACH.

For availing NACH, duly filled and signed physical NACH mandate to be submitted.

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 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 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 insurers.

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.

X. Declaration & Authorization*:

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.

II 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: _____

Product Name : Arogya Sanjeevani Policy, Aditya Birla Health Insurance Co. Limited, Product UIN: ADIHLIP20170V011920.

XI. Vernacular Declaration:

I have explained the contents of this proposal form and all other documents incidental to health insurance from Insurer to the Proposer and understood by him/her. The replies have been recorded as per the information provided by and confirmed by the Proposer.

Declarant Name: _____ Declarant Signature: _____ Date: _____

Proposer Name: _____ Proposer Signature: _____

Proposer Sign Date: _____ Place: _____

XII. Insurance Advisor Report:

Business Source Channel (Please tick the channel applicable and fill details in BLOCK letters)

☐ Agency ☐ Corporate Agency ☐ Direct Sales ☐ Broker ☐ Other Channels

Intermediary Details			
Intermediary Name:	Intermediary Code:	Ref Code 1:	Ref Code 2:
Relationship between Advisor and Proposer/insured			
SP Code (For Corporate Agency channel only)			
RM/LG/Ref Code (For Corporate Agency channel only)			
Sales Manager Name (for All Channels)			
Sales Manager Code (For All Channels)			
ABHI Branch Details (to be filled for all channels)			
Intermediary Branch Name			
Intermediary Branch Code			

I, _____ in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised 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 and that any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer. 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, or if there has been a non-disclosure of any material fact, the policy issued in his/her favor pursuant to this Proposal may be treated as null and void by the Company and all premiums paid under the Policy may be forfeited to the company. I confirm that the proposal form is filled accurately by the customer to the best of my knowledge.

Date: _____

_____
Signature of Agent
(Insurance Advisor Signed date cannot be prior to Customer's Signed date)

XIII. ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER (E-mail id is mandatory):

Do you have an EIA Account: ☐ Yes ☐ No

If Yes, please quote EIA Account Number: _____

Please mention name of Insurance Repository: _____

If No, do you want Us to create an EIA account for you: ☐ Yes ☐ No (if Yes, please fill up Insurance Repository Application Form)

Email Id (Registered with Insurance Repository) : _____

Your address details as mentioned in the EIA account shall override the address provided in this application for Insurance.

Product Name : Arogya Sanjeevani Policy, Aditya Birla Health Insurance Co. Limited, Product UIN: ADIHLIP20170V011920.

XIV. Acknowledgement

Application Number : _____

We acknowledge with thanks the receipt of your application and amount by Cash/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 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, post deduction of applicable pre-policy check up charges if any, received from you without interest. We do not have any liability of claim until the proposal is accepted by us, counter offer if any accepted by you & policy is issued.

Name of the Branch Official : _____ Signature of Branch Official : _____

Date : _____

VII. Information On Health And Lifestyle:

(This page is only use for Medical Section additional information if any)

Insured 1 Name:	
Medical / Surgery history details with Date	

Insured 2 Name:	
Medical / Surgery history details with Date	

Insured 3 Name:	
Medical / Surgery history details with Date	

Insured 4 Name:	
Medical / Surgery history details with Date	

Insured 5 Name:	
Medical / Surgery history details with Date	

Insured 6 Name:	
Medical / Surgery history details with Date	