Health Insurance
Aditya Birla Health Insurance Co. Limited
(A subsidiary of Aditya Birla Capital Ltd.)

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

Activ Health - 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 it is 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: _____

Reference No: ABHI/PROD/20-21/RHI/12

Activ Health, Product UIN: ADIHLIP21574V032021.

I. Proposer Details*:

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

Name*: First* Middle Last*

Correspondence Address*:

City*: _____ **Town (District):** _____

State*: _____ **PIN Code*:** ☐☐☐☐☐☐

Contact Details*:
Mobile Number*: _____ Emergency/Alternate Contact No.: _____
Name and Relation: _____ WhatsApp No., If Different From Mobile Number: _____

Email ID*: (All proposal/policy related communications will be sent on this e-mail id)

Identification Type*: ☐ Aadhar Card ☐ PAN Card ☐ Passport ☐ Driving License ☐ Voter's Identity Card ☐ Others _____ Please mention ID Number _____

PAN: _____ (PAN 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 5 L ☐ 5 to 10 L ☐ 10 L to 20 L ☐ >20 L

Educational Qualification*: Below Matric ☐ Matric ☐ Graduate ☐ Post Graduate ☐ Diploma ☐ Professional Degree ☐ Others ☐ _____

Occupation*: Government Employee ☐ Private Service ☐ Business ☐ Housewife ☐ Retired ☐
Professional
CA ☐ Doctor ☐ Lawyer ☐ Others ☐ _____

Marital Status*: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Seperated

Nationality*: ☐ Indian ☐ Non Resident Indian ☐ Foreign National with Indian Origin <Country>
☐ Person of Indian Origin ☐ Foreign National <Country>
(The Policy, if opted with 'International Coverage for Major Illnesses', can be issued for benefit of Indian citizens residing in India (Insured Person). Cover is not allowed to NRIs, OCIs, PIOs or foreign nationals.)

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

III. Product / Plan Details*:

Plan Type*:	Sum Insured*: (₹)							
☐ Gold - Enhanced	☐ 2 Lac	☐ 3 Lac	☐ 4 Lac	☐ 5 Lac	☐ 6 Lac	☐ 7 Lac	☐ 8 Lac	☐ 9 Lac
	☐ 10 Lac	☐ 15 Lac	☐ 20 Lac	☐ 25 Lac	☐ 30 Lac	☐ 40 Lac	☐ 50 Lac	☐ 100 Lac
	☐ 150 Lac	☐ 200 Lac						
☐ Platinum - Essential	☐ 50,000	☐ 75,000	☐ 1 Lac	☐ 2 Lac	☐ 3 Lac	☐ 4 Lac	☐ 5 Lac	☐ 6 Lac
	☐ 7 Lac	☐ 8 Lac	☐ 9 Lac	☐ 10 Lac	☐ 15 Lac	☐ 20 Lac	☐ 25 Lac	☐ 30 Lac
	☐ 40 Lac	☐ 50 Lac	☐ 100 Lac					
☐ Platinum - Enhanced	☐ 2 Lac	☐ 3 Lac	☐ 4 Lac	☐ 5 Lac	☐ 6 Lac	☐ 7 Lac	☐ 8 Lac	☐ 9 Lac
	☐ 10 Lac	☐ 15 Lac	☐ 20 Lac	☐ 25 Lac	☐ 30 Lac	☐ 40 Lac	☐ 50 Lac	☐ 100 Lac
	☐ 150 Lac	☐ 200 Lac						

Room Type*:	Gold - Enhanced	Platinum - Essential	Platinum - Enhanced
(Applicable for S.I. upto 3L):	☐ Shared Room ☐ Single Private A/C Room	☐ Shared Room ☐ Single Private A/C Room	☐ Shared Room ☐ Single Private A/C Room
(Applicable for S.I. 4L and above):	☐ Shared Room ☐ Single Private A/C Room ☐ Any Room	☐ Shared Room ☐ Single Private A/C Room ☐ Any Room	☐ Shared Room ☐ Single Private A/C Room ☐ Any Room
	Your Premium shall be based on choice of Room Type that You make at the time of Proposal.		
Tenure*:	☐ 1 Year ☐ 2 Years ☐ 3 Years		
Cover*:	☐ Individual ☐ Family Floater		
Mode of Premium Payment*:	☐ Monthly Instalment ☐ Quarterly Instalment ☐ Semi Annual Instalment ☐ Single		

IV. Insured Details*:

☐ Is Proposer also the Insured

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*	<Country>	<Country>	<Country>	<Country>	<Country>	<Country>
City of Residence*						
Height* (cms)						
Weight* (kgs)						
Occupation* (mandatory if Personal Accident Cover(AD,PTD) is opted)						
Designation* (mandatory if Personal Accident Cover(AD,PTD) is opted)						
Nature of Duty* (mandatory if Personal Accident Cover(AD,PTD) is opted)						
Whether Occupation requires significant manual labour/hazardous activities/ handling hazardous material/explosives or working at height/with high voltage or maintenance of law and order? (Yes/No)* (mandatory if Personal Accident Cover(AD,PTD) is opted)						
Sum Insured* (to be filled separately in case of Multi Individual policy)						
Room Type* (to be filled separately in case of Multi Individual policy)						
Email ID*#						
Mobile Number*#						

Reference No: ABHI/PROD/20-21/RHI/12

Activ Health, Product UIN: ADIHLIP21574V032021.

ID Proof No.* (One of Below) ☐ Aadhaar Card ☐ PAN Card ☐ Passport ☐ Driving License ☐ Voter's Identity Card ☐ Others _____ <Document name> ☐ Not Available	<ID Number>	<ID Number>	<ID Number>	<ID Number>	<ID Number>	<ID Number>

(Mobile Number and Email ID is mandatory for each adult Insured. Please mention the Contact Number /Email ID of the Proposer, ONLY in case any Insured's contact number is not available.)

Optional Benefits (Please Tick)	Optional covers under Family Floater Policies, if chosen, will be applicable to all members in the Policy except in case of Personal Accident Cover (AD,PTD), Critical Illness Cover, International Coverage for Major Illnesses. **Please tick Insured 1 for Family Floater**					
	Insured 1	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**
Personal Accident Cover (AD,PTD) (Rs.) Adult Member - To select among the available options on Individual Basis. For Child, applicable Sum Insured 5 Lacs Only.						
	5 Lac ☐ 10 Lac ☐ 15 Lac ☐ 20 Lac ☐ 30 Lac ☐					
Critical Illness Cover (Rs.)						
	3 Lac ☐ 5 Lac ☐ 10 Lac ☐ 15 Lac ☐ 20 Lac ☐					
International Coverage for Major Illnesses Available with base S.I. (under this proposal) of 10L & above only. (The Policy, if opted with 'International Coverage for Major Illnesses', can be issued for benefit of Indian citizens residing in India (Insured Person). Cover is not allowed to NRIs, OCIs, PIOs or foreign nationals.)						
	3 Crores ☐ 6 Crores ☐					
PPN Discount (10% discount available, if opted)						
Waiver of Mandatory Co-payment (Yes/No)						
Maternity Expenses (Yes/No)						
OPD Expenses* (Rs.) (* Road Traffic Accident Diagnostic (over and above OPD Limit): Rs. 10,000)						
	5,000 ☐ 6,000 ☐ 7,000 ☐ 8,000 ☐ 9,000 ☐ 10,000 ☐ 11,000 ☐ 12,000 ☐ 13,000 ☐ 14,000 ☐ 15,000 ☐ 16,000 ☐ 17,000 ☐ 18,000 ☐ 19,000 ☐ 20,000 ☐					
Hospital Cash Benefit (Rs.)						
	500 ☐ 1,000 ☐ 1,500 ☐ 2,000 ☐ 2,500 ☐ 3,000 ☐ 3,500 ☐ 4,000 ☐ 4,500 ☐ 5,000 ☐					

*Mandatory discount applicable for Multi Individual Policy covering 2 or more persons under same Policy.

Zone of Cover	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Zone I (All India Cover)						
Zone II (All India Cover excluding cities in Zone I)						
Zone III (Rest of India excluding cities in Zone I & II)						

Individual Policy: Your Zone is based on the City mentioned in the Proposal form.

Family Floater – A single Zone shall be applicable to all members covered under the Policy, which will be by default the highest Zone applicable amongst the Insured members.

Note: You have an option of upgrading to a higher zone which will enable you to get wider hospital network access outside your zone. If you choose to upgrade your Zone, please tick against the Zone of Cover you would like to opt.
Zone can only be upgraded to higher than default.

V. Previous/ Current Insurance Details:

Do you have **Previous/ Current** Policy or Proposal applied for life/ health/ hospital daily cash/ critical illness / cancer or personal accident insurance?* ☐ Yes ☐ No
If Yes, Please fill the following details with respect to Insurance Policies(s) currently held with Us or any other Insurance Company.

Sr. No.	Previous/Current Insurance Details: *	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1	**Insurer Name**						
2	**Claim in Previous Policy (Yes/No)#**						
3	**Was any proposal/policy declined/ deferred / withdrawn / accepted with modified terms/ cancelled, if "yes" please provide details in additional information (Yes/No)**						

Reference No: ABHI/PROD/20-21/RHI/12

Activ Health, Product UIN: ADIHLIP21574V032021.

4	**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 'Information On Health And Lifestyle' 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

In the event of death of the Proposer, any payment due under the Policy shall become payable to the nominee and the receipt of the proceeds by such nominee would be sufficient discharge to the Company. For all other persons covered under the Policy, the Proposer will be the nominee.

VII. Assignment:

Do you wish to assign this Policy: ☐ Yes ☐ No, Name of Assignee:_____

VIII. Information On Health And Lifestyle*:

Please answer the following questions in "Yes" OR "No" with respect to all persons proposed to be insured. **Note -Please answer all below mentioned questions for each Insured. Please attach discharge card / summary, all consultation papers, investigation reports, histopathology reports, 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 or hospitalized 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
* 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. * Anemia / Any Blood Disorder (whether treated or not). * 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 Gynecological 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						
C. Any of the Insured Persons is pregnant? If yes, please mention the expected Date of Delivery.						
D. Are you suffering from or had suffered in past, any of below conditions? **If YES then fill up Annexure 1.**						
Diabetes (High blood sugar level (YES/NO)						
Hypertension (High Blood Pressure) (YES/NO)						
Hyperlipidemia (High Cholesterol or High Triglycerides) (YES/NO)						
Asthma (YES/NO)						

Reference No: ABHI/PROD/20-21/RHI/12

Activ Health, Product UIN: ADIHLIP21574V032021.

E. Has any of the persons proposed to be insured had						
a. 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?						
F. 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/ glasses of wine] **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**						

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						

Reference No: ABHI/PROD/20-21/RHI/12

Activ Health, Product UIN: ADIHLIP21574V032021.

IX. Premium Payment Details*:

Mode of Premium Payment:

☐ 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 Income Tax Act.

X. 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: _____

Account Type (Current/Saving): _____

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

I agree and undertake to intimate in writing to Aditya Birla Health Insurance Co. Limited about any change in bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

Date: D D M M Y Y Y Y

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.

XI. 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.

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 to 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: _____

XII. 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: _____

Proposer Name: _____ Proposer Signature: _____

Proposer Sign Date: _____ Place: _____

XIII. 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)

XIV. 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 your preferred Insurance Repository (IR): _____

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.

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.

Annexure 1:

Section for Chronic Diseases

To be answered each question* only If You suffer from one or more Chronic Condition of - Diabetes, Hypertension (High Blood Pressure), Hyperlipidemia(High Cholesterol/High Triglycerides) or Asthma

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 or hospitalized 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

Reference No: ABHI/PROD/20-21/RHI/12

Activ Health, Product UIN: ADIHLIP21574V032021.

1. Diabetes Mellitus (High Blood Sugar Level) (YES/NO)						
a. Please mention the medication type- (Oral / Insulin)						
b. Please mention the medicines you are taking (name of medicine and dosages)						
c. Diabetes Diagnosed since birth/childhood (Yes/No)						
d. Duration of Diabetes?						
e. Any Hospitalization done (Yes/No) If YES then mention the details in Additional information section						
2. Hypertension (High Blood Pressure)						
a. Duration of Hypertension?						
b. Please mention the medicines you are taking (name of medicine and dosages)?						
c. Any Hospitalization done (Yes/No) If YES then mention the details in Additional information section						
3. Hyperlipidemia (High Cholesterol or High Triglycerides)						
a. Duration of Hyperlipidemia?						
b. Please mention the medicines you are taking (name of medicine and dosages)?						
c. Any Hospitalization done (Yes/No) If YES then mention the details in Additional information section						
4. Asthma (YES/NO)						
a. Duration of Asthma?						
b. How often do you get Symptoms?	Throughout the day/ Specify frequency	Throughout the day/ Specify frequency	Throughout the day/ Specify frequency	Throughout the day/ Specify frequency	Throughout the day/ Specify frequency	Throughout the day/ Specify frequency
c. Please mention the medicines you are taking (name of medicine /steroids / inhaler / rotahaler /Bronchodilator and their dosages (Daily / On need basis) as prescribed by your doctor?						
d. How often do you have to wake up in the Night on account of the symptoms?	Daily/ Specify frequency	Daily/ Specify frequency	Daily/ Specify frequency	Daily/ Specify frequency	Daily/ Specify frequency	Daily/ Specify frequency
e. How often do you have to take drugs like Steroids (Salbutamol or Formoterol) or Bronchodilator to control your symptoms?	More than twice a day/Specify frequency	More than twice a day/Specify frequency	More than twice a day/Specify frequency	More than twice a day/Specify frequency	More than twice a day/Specify frequency	More than twice a day/Specify frequency
f. Do you have exercise induced asthma? Please mention (YES / NO)	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
g. Do the symptoms hamper/affect your daily routine	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
h. Any Hospitalization done (Yes/No) **If YES, then mention the details in Additional information section.**	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO

Reference No: ABHI/PROD/20-21/RHI/12

Activ Health, Product UIN: ADIHLIP21574V032021.

XV. 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 : _____