Health Insurance

Aditya Birla Health Insurance Co. Limited



Application No.:

Activ Care Proposal Form

- 1. Please select the appropriate options and fill the form in BLOCK LETTERS.
- 2. All details marked with (*) are mandatory.
- 3. Please mention each information accurately as incorrect information may lead to policy cancellation/ claim rejection.
- 4. The Proposer must authenticate each cancellation/ alteration in this form.

Customer ID:			Branch Stamp:		(To be filled by Branch Official)
I. Proposer Details					
Title*: Mr. Mrs.	Ms. Gend	er*: Male F	emale	DOB*: DDMMYY	YY
Name*:	First		Middle	Last	
Correspondence Address*:					
	City*State*		Town (Dis		
Contact Number*:	STD Code L Emergency Contact Number	andline Number	Name a	Mobile Number	*
Email Id*:				(All proposal/policy related co	ommunications will be sent on this e-mail id)
Identification Type*	PAN Card Others	Passport		on ID Number	Do 1.00.000 (irrappositive of the
	PAN No mode of payment of premiun	n) Or > Rs 50,000 accep		ndatory in case premium is >	Rs 1,00,000 (irrespective of the
Email Id of Family Member	(for sharin	g medical report)	Wh	atsApp No. of Family Memb	(for sharing medical report)
GST Registration Status*	Consumer Re		mpounding Dealer	(mandatory	for Registered dealer & Compounding dealer)
UPI Handle			Annual Income		
Marital Status	Single	arried	prced	Widow(er)	Separated
Nationality*	Indian Person of Indian Origin	Non Resident Indian	Foreign Others	National with Indian Origin	
II. Product / Plan D	etails*:				
Tenure*: (Discount applicable on premium 2 year tenure)	for 1 Year	2 Years	Cover*: Individ	dual Family Floater	
Mode of Premium Paymen for 1 year tenure Policy, single pr considered if no option is choser	emium Monthly	Instalment	Quarterly Instalm	ent Semi Annual Ins	talment Single
Plan*	Standar Premier		Suitable Date, time for Pre-policy check (2 dates & time)	-up	

II. Previous/ Current Insurance Details

Do you have Previous/ Current policy for Life/ Health/ Hospital Daily Cash/ Critical Illness / Cancer/ Personal Accident insurance? * Yes If Yes, Please fill the following details with respect to insurance policies(s) currently held with Us or any other insurance company.

S. No.	Previous/Current Insurance Details: *	Insured 1	Insured 2 (spouse of Insured 1)
1	Insurer Name		
2	Claim in previous policy (Yes/No)"		
3	Do you want to consider your health insurance policy for Portability** (Yes / No)		

[&]quot;Please mention details of claim in 'INFORMATION ON HEALTH AND LIFESTYLE' section. ""In case you want portability of previous policy, kindly fill portability form separately.

IV. Nominee Details*:								
Nominee Name		Nominee Relationship wi	th Proposer	Nominee Contact Number				
V. Insured Details*:	·							
Particulars		Insured 1	Ins	ured 2 (spouse of Insured 1)				
Name								
Relationship with Proposer								
Gender								
Date of Birth (DD/MM/YYYY)								
Nationality								
City of Residence								
Height (cms)								
Weight (kgs)								
Email ID (optional)								
Mobile Number (optional)								
Sum Insured (to be filled separately in case of Multi Individual policy, S.I for Insured 1 considered for floater policy)	shall be							
Optional Care Benefits (Please tick)	mer	ional Care Benefits under family nbers in the Policy. For Multi In member.		osen, will be applicable to all tional benefit may be selected for				
Nursing at Home								
Lifestyle support equipment								
Portable medical equipment								
Advance Health Check-up								
Optional Covers (Please tick)				vill be applicable to all members in may be selected for any member.				
Room Upgrade								
PPN (Preferred Provider Network) Discount								
(*) Mandatory. Discount applicable for Multi individual policy covering 2 persons unde	r same Policy.							
VI. Premium Payment Details:								
Type of Premium Payment								
Cash Cheque Demand Draft Online IMPS/ NEFT/ RTGS	Pay Order	r Credit Card	Debit Card					
Instrument Number Instrument Date In	nstrument Amount (₹)	Name of Premium Payer**	Relationship of Payo	er with Bank Details				
		Tromain rayor	1100000					
** Income Tax benefit under section 80D of Income Tax Act, is availabl (Spouse, dependent children & parent). Eligibilities under section 80D			er than cash payment mo	de for himself and his family member				
VII. 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: IFSC Code								
Account Type (Current/Saving):	Account Type (Current/Saving):							

Place: _

Date:_

Signature: _

VIII. Assign	nment:						
Do you wish to a	assign this Policy:	Yes	No, Name of assig	nee:			
D/ 1.5			*				
IX. Informat	tion On Health	n And Li	restyle*:				
				Il persons proposed to be insured. Note - Plea pers, investigation reports, histopathology			
Have you ever be	en diagnosed with /	advised / tal	ken treatment or obser	vation is suggested or undergone any		110	
		_	0 ,	any one or more from the following?	Insured 1	Insured 2 (spouse of Insured 1)	
If YES, then plea	ase mention details	in the addi	tional information se	ction below:			
	art Disease, Periphera ve Replacement, etc		isease, procedures like	Angioplasty/PTCA/By			
			Anaemia / Blood disor	rder (whether treated or not)			
_	3), Asthma any Respi						
*Disease of Eye,	Ear, Nose, Throat, Th	nyroid					
*Cancer, Tumour,	, Lump, Cyst, Ulcer						
				Reproductive /Urinary system, or any past			
	Pregnancy/ child bir Psychiatric/Psycholog		High Blood Pressure or	Diabetes, etc.			
	,			Joints/Arthritis, Congenital/ Birth defect,			
Genetic Disease/	Physical deformity/o	disability, HI\	//AIDS, other Sexually	Transmitted Disease or Accidental injury or			
'	al (other than commo ut of range/ not norr		al fever) or surgical con	dition or Investigation parameter has been			
	-		T. See Left				
		-		er, personal accident insurance declined, lease provide details in additional information			
Do you consume	any of the following	substances?	(if yes, please mention	the quantity)			
Alcohol [30ml (n	number of pegs) of h	ard liquor/ p	ints of beer/ glass of v	vines]/ Week			
Smoking (Numbe	er of Cigarette/bidi s	ticks)/ Week					
Pan Masala/Gutk	ha (Number of small	Pouches)/V	Veek				
Any Other substa	ınce (Name & Quanti	ty)/ Week					
A dditi 1 1 - f	t i Di	l	t= :f= :i-= d				
	mation: Please attac						
Member Name	Details (Disease r (hospitalization/(lity %, Date of Diagnos	is,Last Consultation Date, Name of Surgery (if	any), Details of Treatment	given	
X. Declarat	ion & Authori	zation*:					
				pe insured, that the above statements, answers orized to propose on behalf of these other per		by me are true and	
Lundaneta (1716)	the information	والمراجع المراجع	will forms the basis of	he incurrence policy is subject to the Dec. I	proved up demands to the	of the income and the col	
			of the premium charge	he insurance policy, is subject to the Board ap pable.	proved underwriting policy	of the insurer and that the	
			ange occurring in the o	ccupation or general health of the life to be in pany.	sured/proposer after the p	roposal has been	
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 any insurer to whom	present emp	oloyer concerning anyth	ing which affects the physical or mental healtl e person to be insured/proposer has been made	h of the person to be insur	ed/proposer and seeking	
			aining to my proposal i Governmental and/or Ro	including the medical records of the insured/ μegulatory authority.	proposer for the sole purpo	se of underwriting the	
Date:		Place: _		Signature	9:		
				nent(s) and communications on the e-mail ID communications to the email id as mentioned		•	

Date : _____

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If No, do you want Us to create an EIA account for you:										
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 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. Sirla Health Insurance Co. Limited. IRDAI Reg. 153. CIN No. U66000MH2015PLC263677. Name: Activ Care, Product UIN: ADIHLIP20001V011920. 9 th Floor, Tower 1, One Indiabulls Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone furnbai 400013. Email: care.healthinsurance(@adityabriacapital.com, Website: adityabriahealthinsurance.com, nec 1800 270 7000, Fax: +91 22 6225 7700. For more details on risk factors, terms and conditions please read ad conditions carefully before concluding a sale. Trademark/Logo Aditya Birla Capital is owned by Aditya Birla Health Insurance Co. under licensed user agreement(s). XIV. Acknowledgement Application Number: 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 fu and in time or is not realized. If We do not accept the proposal, We will inform	If No, do you want l	Js to create an EIA account	for you: Yes	No (if	f Yes, please	fill up	Insurance	Repository Application F	Form)	
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