

SILVER HEALTH PROPOSAL FORM

Instructions For Filling Up The Form:-

1. Please answer all questions in BLOCK letters
2. The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid
3. This Proposal will be the basis of any subsequent policy that we issue to you. It is therefore essential that you provide all the information in this Proposal FULLY AND ACCURATELY and that you provide us with any and all additional information relevant to risk to be insured or our decision as to acceptance of the risk or the terms upon which it should be accepted

Proposer Details

[illegible]

2) Are you an existing Bajaj Allianz Customer: Yes / No If yes, please mention the Policy No: OC

3) Gender: ☐ Male ☐ Female ☐ Other 4) Date of Birth | D | D | M | M | Y | Y | Y | Y | 5) PAN No. | | | | | | | |

6) UID/Unique ID:		7) Bajaj Allianz Employee Code, if Proposer is BAGIC/BALIC Employee
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8) Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed 9) No. of Children ☐ Sons ☐ Daughters

10) Occupation ☐ Business ☐ Salaried ☐ Professional ☐ Student ☐ House Wife ☐ Retired Others

11 a) Permanent / Residential Address

House No.					House Name						
Landmark/ Locality											
Road/ Area Name											
City/District											
State					Pin Code						
Tel.											
Mobile											
Email											

12) Educational Qualification: ☐ Matriculate ☐ Under Graduate

13) Family Monthly Income: ☐ Up to Rs. 20,000 ☐ Rs. 20,001 to Rs. 50,000

14) In case of any Offer, you would prefer to be contacted by: ☐ Phone ☐ Email

11 b) Correspondence Address: (All the communications will be sent to the below address)

SSC All the communications will be sent to the below address)

House No.						House Name								
Landmark/ Locality														
Road/ Area Name														
City/District														
State						Pin Code								
Tel.(Res.)														
Tel.(Office)														
Mobile Number														
E-Mail														

☐ Graduate ☐ Post Graduate ☐ Professionally Qualified

☐ Rs. 50,001 to Rs. 1 lakh ☐ Above Rs. 1 lakh

[illegible]

16) Details of the persons to be insured

[illegible]

17) Period of Insurance: From

D	D	M	M	Y	Y	Y	Y
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 To

D	D	M	M	Y	Y	Y	Y
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18) Co-Payment (Waiver for non-network Hospitals) ☐ Yes ☐ No

19) Do you smoke cigarettes or consume tobacco (chewing paste) / alcohol, nicotine or marijuana in any form? ☐ Yes ☐ No
Please give duration and daily consumption _____

20) Has any of the persons to be insured suffer from/or investigated for any of the following?
Disorder of the heart, or circulatory system, chest pain, high blood pressure, stroke, asthma any respiratory conditions, cancer tumor lump of any kind, diabetes, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychiatric conditions, any disease of brain or nervous system, fits (epilepsy) slipped disc, backache, any congenital/ birth defects/ urinary diseases, AIDS or positive HIV. If yes, indicate in the table given below. ☐ Yes ☐ No

21) Have you or any of your immediate family members (father, mother, brother or sister) have/ had cancer, heart attack, or stroke and at What age?
Prior to age 60yrs? ☐ Yes ☐ No

If yes please provide details

☐ Yes ☐ No[illegible][illegible]

☐ "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 the 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 doctor or from a 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 or 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."

☐ I/We have read and understood the Privacy Policy of your Company and I hereby unconditionally agree and bind myself to all terms and conditions of your Privacy Policy, as amended, from time to time.

*** This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer.
 ** Please read declaration wordings carefully before signing the proposal form.

PORTABILITY FORM

PART I

- 1) Name of the Policyholder / insured (s) _____
- 2) Date of Birth / Age _____
- 3) Address of policyholder /insured _____
- 4) Details of existing insurer
 - i. Name of the product _____
 - ii. Sum Insured _____
 - iii. Cumulative Bonus _____
 - iv. Add ons/Riders taken _____
 - v. Policy Number _____
- 5) Details of the proposed insurance
 - i. Name of the product proposed/intended to take _____
 - ii. Sum insured proposed _____
 - iii. Whether Cumulative Bonus to be converted to an enhanced sum insured _____
- 6) Reason (s) of portability _____
- 7) No of family member to be included in the policy to be ported _____

First Name of Insured	Details of Previous Health Insurance Policy / Policy No.	Health ID Card number	Sum Insured	CB	Period of Insurance		First Policy inception date
					From dd/mm/yyyy	To dd/mm/yyyy	

Enclosure: Photocopy of the existing policy documents

Date

D	D	M	M	Y	Y	Y	Y
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Signature of Proposer

PART II

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than existing policy ☐ Yes / ☐ No
(Please indicate Yes /No)
2. If yes , please give written consent to the declaration below:

"I am aware that the waiting period for the following disease (s)/ treatment (s) isdays/years more than the previous policy terms, I hereby agree to observe the additional waiting period for the following diseases (s)/ treatments (s)

Signature of Policyholder