THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI - 400 001.

NEW INDIA PREMIER MEDICLAIM POLICY

PROPOSAL FORM

Agency Details

Name of the Intermediary	
Intermediary Code	
Mobile Number	
Email ID	

The Liability of the company does not commence until the proposal has been accepted and premium has been paid.

This Proposal is the basis for this Policy and any subsequent Renewals that we issue to You and it is therefore necessary that You provide all the information in this Proposal fully and accurately which is material to the acceptance of the risk.

Persons above 50 years of age or persons below 50 years of age having adverse medical history declared in the proposal form will have to undergo pre-acceptance health checkup at a designated hospital/nursing home.

Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy.

1. Proposer's Details:

Name	
Gender	
Occupation	
Educational qualifications	
Family Monthly Income	
Aadhar card No / Passport No / Pan card No	
Landline / Mobile Number	
Residential Address (Permanent)	
Address for Correspondence	
Email ID	
Name of Family Physician	

2. In case of any communication, you would prefer to be contacted by phone, email?

Phone :_____ Mail :_____

3. Details of Members to be Insured:

	Proposer	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name						
Occupation						
Date of Birth						
Gender						
Height in Cms						
Weight Kgs						
Contact Details						
Identity Document Number						
Nature of ID						

4. ABHA NUMBER/ABHA ID*#

Member name	ABHA Number (14 digits)	Consent to share Medical records with Insurers / TPA's through ABHA
		☐ YES / ☐ NO
		☐ YES / ☐ NO
		☐ YES / ☐ NO
		☐ YES / ☐ NO
		☐ YES / ☐ NO
		☐ YES / ☐ NO

 # Note-Disclosing the ABHA ID in this form will not absolve the Proposer/Members from Disclosure of all Material Facts relating to this Insurance.

***Ayushman Bharat Health Account (ABHA) Declaration :** I/We provide my/ our consent to access my/ our (all insured) medical and personal records/ details, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider/s of **The New India Assurance Company Ltd** and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations.

5. Nominee Details

Sr. No.	NAME	Relation	Date of Birth	Appointee Name* (If the Nominee is minor)	Relationship with Minor (Nominee)	% Share nominee is entitled to*

***Note - If only one nominee is mentioned insurer will consider his share is 100%**

6. Period of Insurance : From_____ To _____

7. Plan and Sum Insured Opted:

Plan A		Plan B	
Sum Insured		Sum Insured	
15,00,000		50,00,000	
25,00,000		1,00,00,000	

8. Details of existing / past insurance:

i) Have you OR any other persons proposed for this insurance ever been covered under any health insurance of any insurance company? If yes, please provide policy details.

Name of Insured	Name of Insurer	Policy Details	Sum Insured	Period	First Policy Inception Date	Claims, if any

ii) Has any insurance company refused or declined a proposal for medical insurance for you or any other persons proposed to be Insured in the past? If yes, the details thereof.

Name of the Insured	**Reasons for refusal:**

9. Medical history of proposer / Insured Person:

i) Is the Proposer / Insured Person currently in good health? Yes ☐ No ☐

ii) Please provide Yes / No for the following questions in the table below for all Insured Persons

Questions	Proposer	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
For past 4 years has the person to be insured consulted any physician for treatment or medical investigation or surgical operation,						

Is any Insured Person suffering from Heart disease, Diabetes/raised Blood sugar, High Blood pressure / Hypertension, Circulatory disease						
Has any treatment been taken in the past for Paralysis, cancer, disease of kidney, stomach, intestine, brain, lung or joint disorder, mental Illness						
Has anyone in the past suffered from Congenital stroke, birth defect, physical deformity, or HIV/AIDS						
Have you suffered in the past for Disorders of the eye, ears, nose or throat, gland disorder such as Thyroid, Blood disorder or disorder of the urinary system						
Has any person proposed for Insurance had signs or symptoms or was diagnosed or received Medical Advice / Treatment in respect of any condition, aliment or Injury or related condition in the past 36 months?						
Any other illness, impairment, disability or surgery not mentioned above						

iii) If you have answered Yes to any of the above questions , please furnish the details as below:

Sr. No.	Name of Proposed Insured	Specify Illness with symptoms	Treatment details with treating Doctor's details	Outcome of treatment (e.g. ongoing, complete recovery, recurrent or likely to recur

10. Please Tick ☐ if you wish to receive the physical copy.

By Default Policy documents shall be shared to your Registered Email ID.

11. Declaration: I declare that the persons proposed for insurance are my family members and I also declare that

(STRIKE OUT ONE OF THESE TWO STATEMENTS THAT IS NOT APPLICABLE)

i. None of them suffer from any pre-existing conditions — Yes / No

ii. I have given explicit information of such sickness/disease/injury sustained in the above columns where the information has been sought. — Yes / No

1. "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.
2. 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.
3. 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.
4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time 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.
5. 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."

Signature of Proposer _____

Date :_____ Place : _____

Proposer	Photo Insured 2	Photo Insured 3	Photo Insured 4	Photo Insured 5	Photo Insured 6
Signature	Signature	Signature	Signature	Signature	Signature

Section 41 of Insurance Act, 1938 Prohibition of Rebates

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 the premium shown on the policy, nor shall any person taking out of renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or table of the Insurer.

Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lac rupees.

FOR OFFICE USE ONLY:

S. No.	Name of insured person	Date of Birth	Sex M/F	BMI	Relation	Occupation	Sum Insured	Premium
1								
2								
3								
4								
5								
6								
Remarks of Underwriter:						**Total :**		
						Service Tax		
						Gross Total		

DETAILS OF INTERMEDIARY (AGENT / BROKER / DIRECT)		
Name	:	
Code	:	

NEFT 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.

I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy:

Bank account details as provided below and for which I am submitting a cancelled cheque, should be used by the company for electronic fund transfer as mode of payment.(cancelled cheque should be of the same bank account in which the refund needs to be credited directly)

Particulars of Bank account:

Name(As in Bank Account)	
Name of the Bank	
Name of Branch	
Bank Account Number	
MICR No	
IFSC Code	

I agree and undertake to initiate in writing to **The New India Assurance Company Ltd** about any change in the bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

Proposer/Policy holder's signature:

Date:

DISCLAIMER: **The New India Assurance Company Ltd.** Shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation – failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder.

Aforesaid NEFT transactions shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. **The New India Assurance Company Ltd** shall be indemnified against any loss/damages/claims caused to **The New India Assurance Company Ltd** in carrying out your aforesaid NEFT instructions.

Instructions

- It is important for these electronic payment systems that the policy Holder's name in the Policy must be exactly match with the name in the Bank Account records/details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required
- The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFSC Code, which is applicable to NEFT only.(a number allotted to each participating bank branch) of the branch where the funds need to be transferred.
- Cancelled cheque should be attached along with the NEFT format.
- In case of cancelled bank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required.
- NEFT Form needs complete in all respect.