Leadership and beyond

न्यू इन्डिया एश्योरन्स

NEW INDIA ASSURANCE

THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI 400001

IRDAI Registration No: 190

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. Name of the Nominee_____Relationship _____

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. 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**
Signature	**Signature**	**Signature**

Photo Insured 4	**Photo Insured 5**	**Photo Insured 6**
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	:	