NATIONAL INSURANCE COMPANY LIMITED

(Subsidiary of General Insurance Corporation of India)
Regd. Office : 3, Middleton Street , Calcutta – 700 071

ADRESS OF THE ISSUING OFFICE

PROPOSAL FORM FOR REVISED
MEDICLAIM INSURACNE POLICY

AGENCY CODE : ☐☐☐☐☐ ANNUAL PREMIUM Rs. ☐☐☐☐☐ POLICY No.

DEV. OFFICER CODE : ☐☐☐☐☐

IMPORTANT

(a) The Company will not be on risk until the Proposal and details have been accepted by the Company and Communication of the acceptance has been given to the proposer in writing on full payment of premium.

(b) If other family members residing with proposer (i.e. spouse, eligible dependent children parents) are required to be covered, separate Insured Person Details form should be completed for such family members.

PROPOSER DETAILS

1. Name of the Proposer :
   (surname) (name) FOR OFFICE USE ONLY

2. Address and Telephone No. (I) Residence :

   (ii) Office :

3. Total number of members to be covered (in figures) :
   (in words) :

4. Period of Insurance : / From :
   To : / Midnight

Place:

Date : Signature of the Proposer

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 the 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 punishable with fine which may extend to five hundred rupees.

INSURED PERSON DETAILS

POLCIY NO. :

INSURED PERSON NO. :

ANNUAL PREMIUM :

To be completed separately including Questionnaire form for each Insured Person. (If more than one Insured Person is required to be covered please obtain additional forms from the Company)

1. Name of the Insured Person :

2. Address :
   Pin Code
   State / U. Territory :

3. Sex (Strike out whichever is not Applicable) : Male / Female

4. Relationship with the Proposer :

5. Date of Birth and age :

6. (a) Average monthly Income Rs. :

   (b) Income Tax Pan No. :

7. Profession / Occupation / Trade or Business (Please describe fully with Nature of duties) :

8. Name and address of the Medical Practitioner , his qualifications & Telephone No. if any :

9. Medical Practitioner's Regn. No. :

10. Are you at present or any other time In the past covered under any other Insurance Type (PA, Cancer Insurance, hospitalisation Insurance Or other Medical Insurance), if so, Give particulars of
    (a) Insurer, Policy No. and period Of cover

    (b) Claim Amount Received /

Receivable

Period ……/ From ……../To

11. Any proposal for this Insurance or Any other similar Insurance refused Or higher premium charged if so give Details

12. MEDICAL HISTORY TO BE COMPLETED BY THE PROPOSER / INSURED PERSON

(a) Are you in good health and free from Physical and mental disease or infirmity Or medical Complaints ? :

(b) If not in good health give full details :

13. Have you ever suffered from any of the Disease / illness ? if yes, give details :

(a) Any nervous, mental or psychiatric disease :

(b) Slipped disc or other spinal disorder or (fainting episode, blackout, fit) paralysis of any kind :

(c) High blood pressure, heart disease, including Ischaemic heart disease, other circulatory Disorders etc. (rheumatic fever) :

(d) Fistula, Piles, Hernia, Varicose veins :

(e) Any disease of the bones or joints including Rheumatic disease :

(f) Disease of uterus, ovaries or breast or any Specific gynaecologist disorders :

(g) Any respiratory or allergic disease :

(h) Any disorder of the stomach, ulcer, bowel or Gall bladder , kidney stones etc. :

(i) Any cancer, malignant growth, boil, cyst or Wound etc. which does not heal or improve Despite treatment :

(j) Any other complaint requiring specialist's Consultation or surgical or hospital treatment Or investigations :

(k) Any complaint or tendency that may Nacessitate such consultation or Treatment in the future :

(l) Any dimness of vision / cataract

(m) Any disease of ears or difficulty or Interference with hearing

(n) Diabetes or any urinary disease

(o) Any other illness or disease or accident Or operation sustained by you

14. (a) Have you ever suffered from dental Problems ? Yes/No

(b) if yes, specify same

(c) When were you treated last for same

15. Give particulars in table below of any other illness or disease or accident or operation sustained by you in the past.

	Name if illness / disease injury And treatment received	Date first treated	Name of attending medical pratitioner, surgeon with his address and Telephone No.	Whether fully cured
1				
2				
3				
4				

16. Are there any additional facts Affecting the proposed Insurance Which should be disclosed to Insurers ?

17. Please give details of any knowledge Of any positive existence or presence Of any ailment , sickness or injury Which may require medical attention

1.

2.

3.

4.

18. Please specify Sum Insured option Rs. ……

I hereby declare and warrant that the above statements are true and complete. I consent and authorise the Insurers to seek medical information from any Hospital / Medical Practitioner who has at any time attended or may attend concerning any disease or illness which affects my physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be effected. If after the insurance is effected, it is found that the statements answers or particulars stated in the proposal form and its questionnaire are incorrect or untrue in any respect, the Insurance Company shall incur no liability under this Insurance.

I have read the Prospectus and I/am willing to accept the coverage subject to terms, conditions and exceptions prescribed by the Insurance Company therein.

Signature : ……Date : ☐☐ ☐☐ ☐☐

Place : ……

Name of the Proposer / Insured Person (IN BLOCK LETTERS)……

N.B. : This should necessarily be signed by insured. In case of minor, guardian or proposer may sign.

FOR OFFICE USE ONLY

Basic Premium for scheme : Rs. …… ……..

Family Discount : Rs. ……..

Staff Discount : Rs. ……..

Annexure 'A'

TO BE COMPLETED BY PROPOSER IN CASE OF ADVERSE HISTORY IN THE PROPOSAL FORM IN RESPECT OF APPLICABLE ILLNESS

DIABETES QUESTIONNAIRE

1. Date of diagnosis of Diabetes :
2. Did you suffer from coma or procoma ? :
3. Do you take any antidiabetic drugs ?
   If so, please give name with dose :
4. Please give details of Fasting and
   Postprandial Blood Sugar readings, E.C.G.
   Findings and other investigation reports
   With dates, please also send reports :
5. Do you suffer or have suffered from any
   Complications of diabetes or any other
   Disease ? :

HYPERTENSION QUESTIONNAIRE

1. What your Bloodpressure reading ?
   Please state with dates ? :

2. Please state names of antithypertensive
   Drugs with dose ? :

3. Are you a smoker ? :

4. Is it Essential /Secondary/Malignant
   Hypertension ? :

5. Please state whether you have suffered
   From any complications or other diseases ? :

6. Please give findings of all investigation
   Reports ? :

CHEST PAIN OR CORONARY INSUFFICIENCY OR MYOCARDIAL INFARCTION QESTIONNAIRE

1. Did you ever suffer from chest pain or
   Coronary insufficiency or myocardial
   Infarction ? If so, please give diagnosis
   And date.

2. Please state the name and dose of drugs
   You are taking at present.

3. Please state the findings with dates of
   Investigations done like ECG, Stress test,
   Coronary angiography, X-ray, Pahtology
   Reports etc. Please send reports with the
   Proposal form.

4. Please state the date of hospitalisation and
   Names of hospitals and consultants.

5. Please state complications and other disease,
   If suffered.

6. Please state whether you can do your regular
   Work and whether you have any limitation of
   Activity.

7. Are you advised any special treatment ?
   If so, please give information.

Place :

Date :

_____
Signature of Proposer

Annexur 'B'

(TO BE COMPLETED BY CONSULTING PHYSICIAN / SURGEON)
(IN CASE OF ADVERSE MEDICAL HISTORY)

1. Name of the Insured :

2. HISTORY :

   (a) Present complaints and Investigation, if any :

   (b) Any past history of disease, Operations, accidents, Investigations with date, major Medical complaints of Hospitalisation :

   (c) Details of present and past Medication with duration :

   (d) Is he cured of diseases, if any ? When was your treatment , If any, Given , stopped ? :

3. General Examination :

4. Systematic Examination :

Signature of Consulting Physician……..

Signature of Proposer ……..Name of consulting Physician :

Date : Qualifications :

Place : Address :

Telephone Number :

TO BE COMPLETED BY OFFICIAL OF INSURANCE COMPANY

Do you consider the risk acceptable ?

Competent Authority :

Branch Manager :

Divisional manager :