PROPOSAL FORM

NATIONAL CRITICAL ILLNESS POLICY

Proposal for ☐ **New Policy** ☐ **Renewal (with change in details)**

Period of insurance: From ☐☐☐☐☐☐ **To midnight of** ☐☐☐☐☐☐
DD MM YY DD MM YY

IMPORTANT INSTRUCTIONS

(a) **This Proposal Form shall be the basis of the policy to be issued. It is therefore essential that all the information sought in this Proposal Form and all additional information relevant to the risk to be insured is provided fully & accurately. Please do not leave any space blank, or put dashes**

(b) **The Company will not be on risk until the Proposal have been accepted by the company and communication of the acceptance has been given to the proposer in writing after full payment of premium**

(c) **Details of the proposer and the insured persons can be filled in this Proposal Form. One stamp size photograph of each person are to be affixed on the Proposal Form.**

(d) **List of documents required is provided in Annexure B.**

1. PROPOSER / INSURED DETAILS: Mr. ☐ Ms. ☐ Mrs. ☐

Name: _____

Occupation/Business/Service/Other: _____ **PAN No:** _____ **Aadhaar No:** _____

2. ADDRESS / CONTACT DETAILS:

Address: _____

_____ **District:** _____ **State:** _____ **Pin:** _____

Mobile No: _____ **Email ID:** _____

3. NOMINEE DETAILS:

Name of Nominee: _____ **Date of Birth:** dd / mm / yyyy

Relationship with proposer _____ **PAN no:** _____ **Mobile:** _____ **Email ID:** _____

Name of Guardian (if nominee is minor) _____ **Relationship with proposer** _____

4. BANK DETAILS:

Name in Bank Account: _____

Bank: _____ **Branch:** _____

SB Account No: _____ **IFSC:** _____

5. INSURED PERSON DETAILS

No. of persons covered (including proposer) _____ **(in figure),** _____ **(in words)**
Paste one stamp sized photographs and sign below

Proposer	*Insured Person*	*Insured Person*	*Insured Person*	*Insured Person*	*Insured Person*

All the fields are mandatory. Please do not leave any field blank.

Customer	Proposer	Insured Person	Insured Person	Insured Person	Insured Person	Insured Person
Name						
Date of Birth (mm/dd/yyyy)						
Age						
Gender (M/F)						
Height (cm)						
Weight (kg)						
Blood Group						
Marital Status						
Relationship with Proposer *(for insured person other than proposer)*						
Occupation						
Dependent (Y/N)						
*** Annual Income**						
Do you smoke? (Y/N)						
Do you drink? (Y/N)						
Plan (A or B) *(All family members shall opt for same Plan)*						
Sum Insured *(Sum Insured shall be subject to annual income)*						
Is staff of NIC? *(If Yes, Employee ID)*						

*** Annual income to be supported by IT Certificate/ IT Return**

6. INSURANCE PARTICULARS (previous 3 year and current Health and Critical Illness policies)

Is proposer or any insured person an existing health insurance policyholder? Write Yes/ NA
If yes, please give details and attach Policy copy/ renewal notice

	Company	Policy No.	Policy Name	Expiry Date	Sum Insured	Bonus	Last Claimed Date	Claimed Amount
Proposer								
Insured Person								
Insured Person								
Insured Person								
Insured Person								
Insured Person								

Attach additional Sheet if required.
Please fill Annexure A if porting from other Health Insurance Company to NIC

7. PRE EXISTING CONDITION OF PROPOSER AND INSURED PERSON

If proposer/ any insured person is suffering from any diseases or has signs or symptoms and/or was diagnosed and/or received medical advice/ treatment anytime in past (pre-existing disease/ condition), write Yes/ No. Please do not leave the spaces blank.

	Proposer	Insured Person	Insured Person	Insured Person	Insured Person	Insured Person
Are you in good health, free from physical and mental disease or infirmity or medical complaints?						
Yes/ No						
If No, please specify the illness/disease						

8. PAYMENT DETAILS

Premium Paid by: ☐ Cash ☐ Cheque ☐ DD ☐ Others, specify _____

Amount_____ Date_____/_____/_____Bank Name _____

9. DECLARATIONS

I hereby declare and warrant that the above statements are true and complete. I consent and authorize the Insurers to 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 policy 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 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 proposer or from any past or present employer concerning anything which affects the physical or mental health of the proposer and seeking information from any insurance company to which an application for insurance on the 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.

Place: _____ _____

Date: _____ **Signature of the proposer**

10. IN CASE PROPOSAL FORM IS NOT COMPLETED BY PROPOSER

As per clause no. 3.(4) of Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002, - 'where, for any reason, the proposal and other connected papers are not filled by the proposer, a certificate may be incorporated at the end of proposal form from the proposer that the contents of the form and documents have been fully explained to him/her and that he/she has fully understood the significance of the proposed contract'

CERTIFICATE FROM PROPOSER

The proposal form is filled up by my representative, but the contents of the documents have been fully explained to me and I am willing to accept the coverage subject to terms, conditions and exceptions prescribed by the Insurance Company therein.

Place : _____ _____

Date : _____/_____/_____ **Signature**

Name of the Proposer (in BLOCK LETTERS) _____

N.B. : This should necessarily be signed by proposer, and not by his/her representative.

11. SECTION 41 OF INSURANCE ACT, 1938 – PROHIBITION OF REBATES (Amended as per The Insurance Laws (Amendment) Act, 2015

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 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 liable for a penalty which may extend to ten lakh rupees.**

12. FOR OFFICE USE ONLY

Premium (before discounts) : Rs_____

Net Premium : Rs._____

Intermediary_____Code_____ Date_____/____/_____

Dev. Officer _____Code: _____ Date_____/____/_____

Do you consider the risk acceptable?

Competent Authority: Name _____Designation: _____Signature_____

Policy No. _____Issuing Office: _____ Office code: _____

National Insurance Company Limited,
Registered Office: - 3, Middleton Street, Kolkata-700071
IRDA Registration No: 58
CIN U10200WB1906GOI001713

MEDICAL EXAMINATION REPORT **PART I:** **PERSONAL HISTORY**

Please put the following questions to the person to be assured before carrying out your examination

a)	Full Name :	
b)	Occupation :	
c)	Date of birth :	
d)	Married/Single:	
1	**Are you presently in good health and entirely free from any mental Or physical impairments or deformities?** If not, Please give details: **For Females: Are you now pregnant?** If so, in which month**?**	Yes/No Yes/No
2	**Have you gained or lost weight in the past 12 months?** If so, please give details:	Yes/No
3	**During the last 5 years have you been medically examined, received medical advice or treatment or been in hospital?** If so, please give particulars including details of any X-Rays, E.C.Gs Or other special tests performed:	Yes/No
4	**Is any surgical procedure contemplated?** If so, please give details:	Yes/No
5	**Have you ever suffered from any of the following:** **If so, please give full particulars in the provided or on a separate sheet:** a) Epilepsy, fainting attacks or any disorder of the mental or nervous system? b) Asthma, bronchitis, pleurisy, pneumonia, tuberculosis, or any other lungs complain? c) Chest pain, high blood pressure, palpitations, shortness of breath, stroke or any Heart or circulatory trouble? d) Indigestion, gastric or duodenal ulcer, chronic or recurrent diarrhoea or any complaint of the stomach or bowels? e) Diabetes or any disorder of the kidneys, liver, bladder or urinary system? f) Rheumatic fever, arthritis, gout or any bone or joint disease? g) Enlarged glands or any form of cancer, tumor or disorder of the blood? h) Unexplained recurrent or persistent fever, weight loss or any skin disorder? i) Any sexually transmitted disease (such as syphilis or gonorrhoea) or ever sought medical advice, treatment or a blood test in connection with a viral disease (such as hepatitis B or AIDS)? j) Any disease or disorder of the eyes, ears, nose, throat or mouth? k) Any illness, injury or disability not mentioned above?	Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No
6	**Are you presently taking medication of any kind?** Have you ever received treatment with any blood products or undergone a blood transfusion? Please give details, as appropriate:	Yes/No Yes/No

7 **Please complete the following family history schedule:**

	Age if living	Present state of health	Age at death	Cause of death
1. Father 2. Mother 3. Brother(s) 4. Sister(s)				

8	**What is your normal daily consumption of** (A) alcohol (Please state whether beer, wine or spirit) (B) Tobacco (Please state whether cigarettes, cigarillos, cigars or pipe)	
9	**Have you ever taken drugs other than those prescribed by a doctor?** If so, please give details:	Yes/No

I confirm that all of the above answers and statements are true and that no material facts concerning my past and present state of health and habits have been withheld or omitted. I also agree that any doctor, whether named above or not, who has attended or examined me or who may do so hereafter shall be and is hereby authorized and directed by me to disclose to the company any information he may have acquired with regard to myself.

Date:

Signature of person to be insured **Signature of Medical Examiner**

MEDICAL EXAMINATION REPORT PART II: MEDICAL EXAMINER'S FINDINGS AND ASSESSMENT

Please answer each question and where appropriate provide particulars. you are asked not to give the person to be assured any information about the results of your examination.

1	Full Name of the Assured:	
2	**In which way have you satisfied yourself of the Identity of the person examined** Do you know the person to be assured? Have you previously examined, advised or treated the person to be insured?	 Yes/No Yes/No
3	**Is there anything unfavorable in the appearance or development of the person to be assured?** Is there any reason to suspect intemperate habits?	Yes/No Yes/No
4	**Height / Weight** Chest measurements in cms (insp./exp.): and Girth of abdomen(cm):	…….Cms. …….Kgs ……..&……..
5	**Do you consider the musculo-skeletal system to be healthy?**	Yes/No
6	**Do you consider the skin and mucous membranes to be healthy?**	Yes/No
7	**Do you consider the respiratory organs to be healthy?**	Yes/No
8	**Do you consider the teeth, tongue, mouth and throat to be healthy?**	Yes/No
9	**Is there evidence of cardiac hypertrophy?** a) Are the heart sounds normal? b) Are there any murmurs? If so, please describe them fully, including site, timing, intensify and transmission. Also indicate the effect of posture or respiration. What is the blood pressure in mm Hg (systolic/diastolic)? Please note that the diastolic level is to be taken at the cessation of all sound. 1st Reading: 2nd Reading: Please provide two further readings at 5 to 10 minutes intervals if the first reading exceeds 140/90. 3rd Reading: c) What is the pulse rate? d) Is the pulse normal in character? e) Are any arteriosclerotic changes evident or to be presumed? f) Are the foot pulses palpable? g) Are there any varicose veins or ulcers?	Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No
10	**Is there any abnormality of the abdomen, liver or spleen on inspection, palpation or percussion?** Do you consider the digestive organs to be healthy?	Yes/No Yes/No
11	**Urine analysis** The urine should be passed during the medical examination. If not, please state circumstances: If albumin is found, please arrange to examine an early morning specimen. First specimen: Early morning specimen: **Do you consider the urinary and genital organs to be healthy?** **For female:** If pregnant, are any complications to be expected?	 Albumin: Sugar: Others (please specify) Albumin: Sugar: Others (please specify) Yes/No Yes/No
12	Are there any other abnormal findings not indicated above (e.g. glandular swellings) ?	Yes/No
13	Are you aware of anything about the person to be assured's lifestyle which may increase the risk of HIV infection?	Yes/No
14	Is there any further evidence, medical or otherwise, which you think should be obtained in order to assess the person to be assured's suitability for Life Assurance/Disability Insurance?	Yes/No
15	Based on your physical examination sand the disclosed medical & family history please indicate how you would classify the person to be assured's suitability for Life Assurance/Disability Insurance: First Class (i.e. lives which present no adverse circumstances) Second Class (i.e. lives where adverse circumstances are such as to require a small additional premium) Third Class (i.e. lives where adverse circumstances are such as to require a considerable increase in the ordinary premium rate) Fourth Class (i.e. lives where adverse circumstances are so serious that declinature is recommended)	

Name of Medical Examiner & qualification:
Regd.No:
Address: **Signature of Medical Examiner**
Date:

Annexure A

Policy No. :
Name of Insured Person :

To be completed by the insured in case of porting from a health insurance policy issued by another insurance company

Portability Form

1)	Name of the Policyholder / insured (s)	
2)	Date of Birth/Age	
3)	Address of the policyholder/insured	
4)	Details of existing insurer	
	i. Name of insurance company	
	ii. Name of the product	
	iii. Sum Insured	
	iv. Cumulative Bonus	
	v. Add-ons/riders taken	
	vi. Policy number	
5)	Details of the proposed insurance	
	i. Name of the product proposed/intend to take	
	ii. Sum Insured Proposed	
	iii. Whether Cumulative Bonus to be converted to an enhanced sum insured	
6)	Reason(s) for Portability	
7)	No. of family members to be included in the policy to be ported	
Enclosure: Photocopy of the existing & previous policy documents		
Date: Signature of the policyholder		

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy? (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) is more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s).

Name of disease/ treatment	Waiting period in days/ years
1. 2. 3. 4.	

Place :

Date :

_____

Signature of the policyholder

National Insurance Co. Ltd. Annexure B

Documents required

1. Completed proposal form
2. Cancelled cheque (supporting bank account details)
3. Stamp size photograph (1 nos) for each insured person
4. Pre policy check up reports (if applicable)
5. Copy of existing health insurance policies (if applicable)
6. Proof of identity (any one document listed below)
7. Proof of residence (any one document listed below)
8. Copy of IT Certificate/ IT Return (wherever applicable)
9. Pan Details (in case PAN not available, Form 60 or 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted)

Documentary proof

Features	**Documents**
Proof of identity	i. Passport ii. PAN Card iii. Voter's Identity Card iv. Driving License v. Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer vi. Personal identification and certification of the employees of the insurer for identity of the prospective policyholder. vii. Letter issued by Unique Identification Authority of India containing details of name, address and Aadhar number viii. Job card issued by NREGA duly signed by an officer of the State Government
Proof of Residence	i. Telephone bill pertaining to any kind of telephone connection like, mobile, landline, wireless, etc. provided it is not older than six months from the date of insurance contract ii. Current Passbook with details of permanent/present residence address (updated upto the previous month) iii. Current statement of bank account with details of permanent/present residence address (as downloaded) iv. Letter from any recognized public authority v. Electricity bill vi. Ration card vii. Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof viii. Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)
Proofs of both Identity and Residence	Written confirmation from the banks where the proposer is a customer, regarding identification and proof of residence.