Health Insurance
Aditya Birla Health Insurance Co. Limited

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

Activ Care Proposal Form

Application No.:

1. Please select the appropriate options and fill the form in BLOCK LETTERS.
2. All details marked with (*) are mandatory.
3. Please mention each information accurately as incorrect information may lead to policy cancellation/ claim rejection.
4. The Proposer must authenticate each cancellation/ alteration in this form.

Customer ID: _____ Branch Stamp: (To be filled by Branch Official)

I. Proposer Details:

Gender*: ☐ Male ☐ Female ☐ Others **DOB*:** D D M M Y Y Y Y

Name*:	First Middle Last
Correspondence Address*:	**City*** _____ Town (District) _____ **State*** _____ **PIN Code***
Contact Number*:	STD Code _____ Landline Number _____ **Mobile Number*** _____ Emergency Contact Number _____ **Name and Relationship** _____
Email Id*:	(All proposal/policy related communications will be sent on this e-mail id)
Identification Type*	☐ PAN Card ☐ Passport ☐ Driving License ☐ Others _____ Please mention ID Number _____
Email Id of Family Member	(for sharing medical report) **WhatsApp No. of Family Member** (for sharing medical report)
GST Registration Status*	☐ Consumer ☐ Registered Dealer ☐ Compounding Dealer Please specify GST Identity Number: _____ (mandatory for Registered dealer & Compounding dealer)
PAN No.:	_____ (PAN No. is mandatory in case premium is > Rs 1,00,000 (irrespective of the mode of payment of premium) Or > Rs 50,000 accepted in Cash)
UPI Handle	Annual Income
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated
Nationality*	☐ Indian ☐ Non Resident Indian ☐ Foreign National with Indian Origin ☐ Person of Indian Origin ☐ Others _____

☐ I want to opt for GO-GREEN and receive all my policy related document(s) and communications on the e-mail ID provided in this proposal form. I/We hereby authorize Aditya Birla Health Insurance Company Limited to mail all service related communications to the email id as mentioned in the application form (applicable only if email id provided).

II. Product / Plan Details*:

Tenure*: (Discount applicable on premium for 2 year tenure)	☐ 1 Year ☐ 2 Years	**Cover*:** ☐ Individual ☐ Family Floater	
Mode of Premium Payment (Available only for 1 year tenure Policy, single premium considered if no option is chosen)	☐ Monthly Instalment ☐ Quarterly Instalment ☐ Semi Annual Instalment ☐ Single		
Plan*	☐ Standard ☐ Classic ☐ Premier	Suitable Date, time for Pre-policy check-up (2 dates & time)	

III. Insured Details*:

Particulars	Insured 1	Insured 2 (spouse of Insured 1)
Name		
Relationship with Proposer		
Gender		
Date of Birth (DD/MM/YYYY)		

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Nationality		
City of Residence		
Height (cms)		
Weight (kgs)		
Email ID (optional)		
Mobile Number (optional)		
Sum Insured (to be filled separately in case of Multi Individual policy, S.I for Insured 1 shall be considered for floater policy)		
Optional Care Benefits (Please tick)	Optional Care Benefits under family floater policies, if chosen, will be applicable to all members in the Policy. For Multi Individual policy, any optional benefit may be selected for any member.	
Nursing at Home		
Lifestyle support equipment		
Portable medical equipment		
Advance Health Check-up		
Optional Covers (Please tick)	Optional Covers under family floater policies, if chosen, will be applicable to all members in the Policy. For Multi Individual policy, any optional cover may be selected for any member.	
Room Upgrade		
PPN (Preferred Provider Network) Discount		

(*) Mandatory.
Discount applicable for Multi individual policy covering 2 persons under same Policy.

IV. Previous/ Current Insurance Details:

Do you have **Previous/ Current** policy for Life/ Health/ Hospital Daily Cash/ Critical Illness / Cancer/ Personal Accident insurance? * ☐ Yes ☐ No
If Yes, Please fill the following details with respect to insurance policies(s) currently held with Us or any other insurance company.

S. No.	Previous/Current Insurance Details: *	Insured 1	Insured 2 (spouse of Insured 1)
1	Insurer Name		
2	Claim in previous policy#(Yes/No)		
3	Do you want to consider your health insurance policy for Portability## (Yes / No)		

Please mention details of claim in 'INFORMATION ON HEALTH AND LIFESTYLE' section.
In case you want portability of previous policy, kindly fill portability form separately.

V. Nominee Details*:

Nominee Name	Nominee Relationship with Proposer	Nominee Contact Number

VI. Assignment:

Do you wish to assign this Policy: ☐ Yes ☐ No, Name of assignee:_____

VII. Information On Health And Lifestyle*:

Please answer the following questions in "Yes" OR "No" with respect to all persons proposed to be insured. **Note - Please answer all below mentioned questions for each Insured. Please attach discharge card / summary, all consultation papers, investigation reports, histopathology repots, disability certificate from civil surgeon if any.**

Have you ever been diagnosed with /advised / taken treatment or observation is suggested or undergone any investigation or consulted a doctor or undergone or advised surgery for any one or more from the following? **If YES, then please mention details in the additional information section below:**	Insured 1	Insured 2 (spouse of Insured 1)
*Any form of Heart Disease, Peripheral Vascular Disease, procedures like Angioplasty/PTCA/By Pass Surgery, Valve Replacement, etc. *Diabetes, High Blood Pressure, High Cholesterol, Anaemia / Blood disorder (whether treated or not) *Tuberculosis (TB), Asthma any Respiratory / Lung disease *Disease of Eye, Ear, Nose, Throat, Thyroid *Cancer, Tumour, Lump, Cyst, Ulcer *Disease of Kidney, Digestive Tract, Liver/Gall Bladder, Pancreas, Breast, Reproductive /Urinary system, or any past complications of Pregnancy/ child birth including High Blood Pressure or Diabetes, etc. *Mental Illness, Psychiatric/Psychological Disorder *Disease of the Brain/Spine/Nervous System, Epilepsy, Paralysis, Polio, Joints/Arthritis, Congenital/ Birth defect, Genetic Disease/Physical deformity/disability, HIV/AIDS, other Sexually Transmitted Disease or Accidental injury or any other medical (other than common cold & viral fever) or surgical condition or Investigation parameter has been detected to be out of range/ not normal		

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Was any proposal for life, health, hospital daily cash, critical illness, cancer, personal accident insurance declined, deferred, withdrawn or accepted with modified terms/cancelled? If yes, please provide details in additional information		
Do you consume any of the following substances?(if yes, please mention the quantity)		
Alcohol [30ml (number of pegs) of hard liquor/ pints of beer/ glasses of wine]/**Week**		
Smoking (Number of Cigarette/bidi sticks)/**Week**		
Pan Masala/Gutkha (Number of small Pouches)/**Week**		
Any Other substance (Name & Quantity)/**Week**		

Additional Information: Please attach extra sheets if required

Member Name	Details (Disease name, Disability %, Date of Diagnosis,Last Consultation Date, Name of Surgery (if any), Details of Treatment given (hospitalization/OPD, other)

VIII. Premium Payment Details:

Type of Premium Payment

☐ Cash ☐ Cheque ☐ Demand Draft ☐ Pay Order ☐ Credit Card ☐ Debit Card

☐ Online ☐ IMPS/ NEFT/ RTGS

Instrument Number	Instrument Date	Instrument Amount (₹)	Name of Premium Payer**	Relationship of Payer with Proposer	Bank Details

** Income Tax benefit under section 80D of Income Tax Act, is available to the person who pays the health insurance premium by other than cash payment mode for himself and his family member (Spouse, dependent children & parent). Eligibilities under section 80D are subject to Income Tax Act.

IX. Bank Account 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.

Name as in Bank Account: _____

Bank Name: _____ Account Number: _____

Bank Branch: _____ IFSC Code: _____ Bank City: _____

Account Type (Current/Saving): _____

In case of payment through Debit Card, Credit Card and Online Mode of payment, the refund goes back to the same card or bank account as the case may be.

Date:_____ **Place:** _____ **Signature:** _____

X. Declaration & Authorization*:

I 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 am 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 insurer and that the policy will come into force only after full payment of the premium chargeable.

I further declare that I 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 declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

I authorize the company to share information pertaining to my proposal including the medical records of the insured/ proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.

I hereby consent to and authorize Aditya Birla Health Insurance Company to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of the Company from time to time.

Date:_____ Place: _____ Signature: _____

XI. Vernacular Declaration:

I have explained the contents of this proposal form and all other documents incidental to health insurance from Insurer to the Proposer and understood by him/her. The replies have been recorded as per the information provided by and confirmed by the Proposer.

Declarant Name: _____ Declarant Signature: _____ Date: _____

Proposer Name: _____ Proposer Signature: _____

Proposer Sign Date: _____ Place: _____

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XII. Insurance Advisor Report:

Business Source Channel (Please tick the channel applicable and fill details in BLOCK letters)

☐ Agency ☐ Corporate Agency ☐ Direct Sales ☐ Broker ☐ Other Channels

Intermediary Details	
Intermediary Name	
Intermediary Code	
Ref Code 1	
Ref Code 2	
SP Code (For Corporate Agency channel only)	
RM/LG/Ref Code (For Corporate Agency channel only)	
Sales Manager Name (for All Channels)	
Sales Manager Code (For All Channels)	
ABHI Branch Details (to be filled for all channels)	
Intermediary Branch Name	
Intermediary Branch Code	

I, _____ in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer and that any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer,. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, or if there has been a non-disclosure of any material fact, the policy issued in his/her favor pursuant to this Proposal may be treated as null and void by the Company and all premiums paid under the Policy may be forfeited to the company. I confirm that the proposal form is filled accurately by the customer to the best of my knowledge.

Date: _____

_____
Signature of Agent
(Insurance Advisor Signed date cannot be prior to Customer's Signed date)

XIII. ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER (E-mail id is mandatory):

Do you have an EIA Account: ☐ Yes ☐ No
If Yes, please quote EIA Account Number: _____
Please mention name of Insurance Repository: _____
If No, do you want Us to create an EIA account for you: ☐ Yes ☐ No (if Yes, please fill up Insurance Repository Application Form)
Email Id (Registered with Insurance Repository) : _____
Your address details as mentioned in the EIA account shall override the address provided in this application for Insurance.

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 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.

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Aditya Birla Health Insurance Co. Limited. IRDAI Reg.153. CIN No. U66000MH2015PLC263677.
Product Name: Activ Care, Product UIN: ADIHLIP21062V022021.
Address: 9th Floor, Tower 1, One Indiabulls Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013. Email: care.healthinsurance@adityabirlacapital.com, Website: adityabirlahealthinsurance.com, Telephone: 1800 270 7000, Fax: +91 22 6225 7700. Trademark/Logo Aditya Birla Capital is owned by Aditya Birla Management Corporation Private Limited and Trademark/logo HealthReturns, Healthy Heart Score and Active Dayz are owned by Momentum Metropolitan Life Limited (Formerly known as MMI Group Limited). These trademark/Logos are being used by Aditya Birla Health Insurance Co. Limited under licensed user agreement(s).

Contact us:
1800 270 7000

ADITYA BIRLA CAPITAL

XIV. Acknowledgement

Application Number : _____

We acknowledge with thanks the receipt of your application and amount by Cash/Cheque/Demand Draft/ Others _____ of amount of

Rs. _____ dated _____ drawn on _____ . Neither the submission to Us of a completed proposal for insurance nor any payment for any policy sought obliges Us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If We accept a proposal for insurance, it shall be subject to the policy terms and conditions and We shall have no liability whatsoever if premium is not received by Us in full and in time or is not realized. If We do not accept the proposal, We will inform you and refund the payment, post deduction of applicable pre-policy check up charges if any, received from you without interest. We do not have any liability of claim until the proposal is accepted by us, counter offer if any accepted by you & policy is issued.

Name of the Branch Official : _____

Signature of Branch Official : _____

Date : _____