ADITYA BIRLA CAPITAL
HEALTH INSURANCE

Activ One
Proposal Form

This document summarizes all relevant information about the person / people proposed to be insured under your health insurance policy including age, medical history, lifestyle habits, pre-existing diseases, if any, and the risks to be covered. As an insurer, it helps us to assess risks, determine premiums, establish terms and conditions and to be relevant to you and your health needs. It is vital that you provide us with complete and accurate information.

1. Please choose suitable options wherever applicable and fill the form in BLOCK LETTERS.
2. The proposed policy holder will be referred to in this Proposal Form as "Proposer", "You" or "Your".
3. Please disclose truthfully and accurately all facts and required information that is likely to impact / affect our decision on issuing a health insurance policy or its terms, conditions and exclusions. Incorrect information may lead to policy cancellation / claim rejection. In case of untrue / incorrect statements, misrepresentation, non-description or non-disclosure of any relevant information or material information being withheld by the Proposer or anyone acting on their behalf, particularly in the proposal form / personal statement, declaration and connected documents, the policy shall become void at our discretion. If You are in any doubt, please seek the advice of your insurance advisor.
4. In case of a portability proposal, the health insurance policy period will only begin after complete premium payments including loading premium (if applicable) are submitted by You. This may result in a break in coverage period, in which case You may not be covered by any policy. It is therefore recommend that You extend Your porting policy with existing insurer on short period basis until this proposal is accepted and issued by us in case of portability request. The Company's liability does not commence until the acceptance of the proposal has been formally intimated to You and full premium has been realized by the Company.
5. Any changes / cancellations in this form will have to be authenticated by the Proposer.

Application No.

Customer ID _____

Branch Stamp _____

I. Proposer Details

Name:	First Name	Middle Name	Last Name
Gender: ☐ M ☐ F ☐ Other	**Date of Birth:** DD/MM/YYYY	**Marital Status:** ☐ Single ☐ Married ☐ Others (Divorced / Widow(er) / Separated / Live-in partner)	
Whether Employee of Aditya Birla Group	(If Yes) Employee ID		
Whether Customer of Aditya Birla Group	(if Yes) Name of the Company and product purchased		
Whether Corporate GMC Policy Holder	(if Yes) Name of the Corporate and GMC COI Number		
Correspondence Address (For premium computation, zone shall be considered as per correspondence address)	Address Line 1 Address Line 2 City: City — Town (District): Town (District) State: State — Pin Code: ☐☐☐☐☐☐ Gram Panchayat: — Gram Panchayat Code:		
Permanent Address	Same as Correspondence Address or Address Line 1 Same as Correspondence Address or Address Line 2 City: City — Town (District): Town (District) State: State — Pin Code: ☐☐☐☐☐☐ Gram Panchayat: — Gram Panchayat Code:		
Nationality	☐ Indian ☐ Other than Indian (Please specify)		
PAN (Mandatory)	_____ Form 60 (only in case the customer does not have PAN) ☐ Yes ☐ No		
Aadhaar Number (last 4 digits) (by signing the proposal Form I give my consent for using my Aadhaar No. for authentication of my Aadhaar details)	XXXX XXXX XXXX ☐☐☐☐	**GST Registration Status** ☐ Consumer ☐ Registered Dealer ☐ Compounding Dealer Please specify GST identity Number:_____(mandatory for Registered dealer & Compounding dealer)	
Proof of Address (POA - any one)	☐ Electricity Bill (not older than 3 months) ☐ Aadhaar ☐ Passport ☐ Ration Card ☐ Driving License ☐ Telephone Bill (not older than 3 months) ☐ Bank Account Statement (not older than 3 months) ☐ Other _____		

Contact Details	Mobile Number*_____ Alternate Contact Number _____
E-mail ID+ (All proposal / policy related communications will be sent on this e-mail id)	_____
Annual Income (INR)	☐ Up to 5 Lacs ☐ 5 Lacs to 10 Lacs ☐ 10 Lacs to 20 Lacs ☐ >20 Lacs
Occupation	☐ Government Employee ☐ Private Service ☐ Business ☐ Housewife ☐ Retired ☐ Professional ☐ CA ☐ Doctor ☐ Lawyer ☐ Others _____
Are you a Politically Exposed Person (PEP) or related to PEP#?	☐ Yes ☐ No
WhatsApp consent^:	☐ No
Do you have ABHA No.?	☐ Yes ☐ No If Yes, Ayushman Bharat Health Account (ABHA) No. (Optional) _____
Go Green consent	☐ I would like to contribute in creating a healthier, greener and cleaner environment by authorizing Aditya Birla Health Insurance Co. Limited to send all my policy & service related communication to the E-mail ID mentioned in this application form.
	☐ I choose to have hard copy of policy document.

*The registered mobile number will be enrolled for WhatsApp notifications related to your Health Insurance Policy. We respect your privacy and will ensure that promotional content is not shared through this channel. ^If You don't want to give consent and authorize Aditya Birla Health Insurance Co. Limited to send you communication via WhatsApp please select 'No' in WhatsApp consent column.

#Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, Senior Politicians, Senior Government, Judicial or Military Officials, Senior Executives of State Owned Corporations or Important Political Party Officials.

IA. Electronic Insurance Account Details of Proposer (E-Mail ID+ is mandatory)

Would you like to opt for Electronic Policy Issuance through an e-Insurance Account (eIA) of an Insurance Repository? ☐ Yes ☐ No	
If you have an eIA, please provide following details	
1) Name of Insurance Repository	
2) eIA No.	
3) Name as appearing in eIA	
If you do not have an eIA, would you like to open an account? ☐ Yes ☐ No (If Yes, please fill up Insurance Repository Application Form)	

II. Product / Plan Details

Plan Type:	**Sum Insured Options (INR)**	
☐ MAX ☐ VYTL ☐ NXT	☐ 2 Lacs ☐ 3 Lacs ☐ 4 Lacs ☐ 5 Lacs ☐ 7 Lacs ☐ 10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs ☐ 50 Lacs ☐ 75 Lacs ☐ 1 Crore ☐ 2 Crores ☐ 3 Crores ☐ 4 Crores ☐ 5 Crores ☐ 6 Crores	
☐ VIP ☐ VIP+	☐ 50 Lacs ☐ 75 Lacs ☐ 1 Crore ☐ 2 Crores ☐ 3 Crores ☐ 4 Crores ☐ 5 Crores ☐ 6 Crores	
☐ SAVR	☐ 2 Lacs ☐ 3 Lacs ☐ 4 Lacs ☐ 5 Lacs ☐ 7 Lacs ☐ 10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs ☐ 50 Lacs ☐ 75 Lacs ☐ 1 Crore ☐ 2 Crores ☐ 3 Crores ☐ 4 Crores ☐ 5 Crores ☐ 6 Crores	Details for Hospital Cash Cover of Parents OR Parents-in-law ☐ Parents ☐ Father Name_____ & Age___ ☐ Mother Name_____ & Age___ OR ☐ Parents-in-law ☐ Father-in-law Name_____ & Age_____ ☐ Mother-in-law Name_____ & Age_____
☐ MAX+	☐ 2 Lacs ☐ 3 Lacs ☐ 4 Lacs ☐ 5 Lacs ☐ 7 Lacs ☐ 10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs ☐ 50 Lacs ☐ 75 Lacs ☐ 1 Crore ☐ 2 Crores ☐ 3 Crores ☐ 4 Crores ☐ 5 Crores ☐ 6 Crores	
Cover : ☐ Individual ☐ Family Floater	Tenure: ☐ 1 Year ☐ 2 Years ☐ 3 Years	
Details of Optional Cover(s) as per Annexure - I	Mention 'ATTACHED' if one or more optional covers opted	

III. Details of The Proposed To Be Insured Including Proposer

Insured 1: Name: Dr. / Mr. / Ms. / Mrs.		**If PEP#:** ☐ Yes ☐ No
Date of Birth: DD/MM/YYYY	**Marital Status:**	**Annual Income:**
Gender: ☐ M ☐ F ☐ Other	**Aadhaar / PAN:**	**Height:** Cms **Weight:** KG
Mobile No.~:	**Relationship with Proposer$:**	**City of Residence:**
E-Mail ID~:	**Nationality:** ☐ Indian ☐ Other than Indian (Specify country name)	**Sum Insured%: (INR)** (Specify the SI opted)
Do you have ABHA No. ☐ Yes ☐ No	**If yes please provide ABHA Number (Optional)**	

Insured 2: Name: Dr. / Mr. / Ms. / Mrs.		**If PEP#:** ☐ Yes ☐ No
Date of Birth: DD/MM/YYYY	**Marital Status:**	**Annual Income:**
Gender: ☐ M ☐ F ☐ Other	**Aadhaar / PAN:**	**Height:** Cms **Weight:** KG
Mobile No.~:	**Relationship with Proposer$:**	**City of Residence:**
E-Mail ID~:	**Nationality:** ☐ Indian ☐ Other than Indian (Specify country name)	**Sum Insured%: (INR)** (Specify the SI opted)
Do you have ABHA No. ☐ Yes ☐ No	**If yes please provide ABHA Number (Optional)**	

Insured 3: Name: Dr. / Mr. / Ms. / Mrs.		**If PEP#:** ☐ Yes ☐ No
Date of Birth: DD/MM/YYYY	**Marital Status:**	**Annual Income:**
Gender: ☐ M ☐ F ☐ Other	**Aadhaar / PAN:**	**Height:** Cms **Weight:** KG
Mobile No.~:	**Relationship with Proposer$:**	**City of Residence:**
E-Mail ID~:	**Nationality:** ☐ Indian ☐ Other than Indian (Specify country name)	**Sum Insured%: (INR)** (Specify the SI opted)
Do you have ABHA No. ☐ Yes ☐ No	**If yes please provide ABHA Number (Optional)**	

Insured 4: Name: Dr. / Mr. / Ms. / Mrs.		**If PEP#:** ☐ Yes ☐ No
Date of Birth: DD/MM/YYYY	**Marital Status:**	**Annual Income:**
Gender: ☐ M ☐ F ☐ Other	**Aadhaar / PAN:**	**Height:** Cms **Weight:** KG
Mobile No.~:	**Relationship with Proposer$:**	**City of Residence:**
E-Mail ID~:	**Nationality:** ☐ Indian ☐ Other than Indian (Specify country name)	**Sum Insured%: (INR)** (Specify the SI opted)
Do you have ABHA No. ☐ Yes ☐ No	**If yes please provide ABHA Number (Optional)**	

Insured 5: Name: Dr. / Mr. / Ms. / Mrs.		**If PEP#:** ☐ Yes ☐ No
Date of Birth: DD/MM/YYYY	**Marital Status:**	**Annual Income:**
Gender: ☐ M ☐ F ☐ Other	**Aadhaar / PAN:**	**Height:** Cms **Weight:** KG
Mobile No.~:	**Relationship with Proposer$:**	**City of Residence:**
E-Mail ID~:	**Nationality:** ☐ Indian ☐ Other than Indian (Specify country name)	**Sum Insured%: (INR)** (Specify the SI opted)
Do you have ABHA No. ☐ Yes ☐ No	**If yes please provide ABHA Number (Optional)**	

Insured 6: Name: Dr. / Mr. / Ms. / Mrs.		**If PEP#:** ☐ Yes ☐ No
Date of Birth: DD/MM/YYYY	**Marital Status:**	**Annual Income:**
Gender: ☐ M ☐ F ☐ Other	**Aadhaar / PAN:**	**Height:** Cms **Weight:** KG
Mobile No.~:	**Relationship with Proposer$:**	**City of Residence:**
E-Mail ID~:	**Nationality:** ☐ Indian ☐ Other than Indian (Specify country name)	**Sum Insured%: (INR)** (Specify the SI opted)
Do you have ABHA No. ☐ Yes ☐ No	**If yes please provide ABHA Number (Optional)**	

$**In case of family floater** maximum of 2 Adults and up to 4 Children are allowed (Relationship covered: Self, legally married spouse OR live-in partner (same or opposite sex), Dependent Children (Natural / legally adopted), Parents and Parents-in-law) and **In case of Multi-individual policy, relationship covered:** Self, legally married spouse OR live-in partner (same or opposite sex), son, daughter, brother, sister, grandson, granddaughter, son-in-law, daughter-in-law, brother-in-law, sister-in-law, nephew, niece, parents and parents-in-law.

~Mobile Number and E-Mail id is mandatory for each adult insured. Mention the Mobile Number / E-Mail id of the proposer ONLY in case any Insured's Mobile Number is not available.

%In case of Multi Individual policy, Sum Insured opted to be filled separately for each Insured Person and in case of Family Floater, the Sum Insured opted in section II Product / Plan details above shall be applicable to all members.

IV. Previous / Current Insurance Details

Do you have **Previous / Current** policy or proposal applied for Life, Health, Hospital Daily Cash or Critical Illness or Cancer or 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.

SR. No.	Previous / Current Insurance Details:	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1	Insurer Name						
2	Claim in Previous Policy (YES / NO)#						
3	Was any proposal / policy declined / deferred / withdrawn / accepted with modified terms / cancelled, if "Yes" please provide details in additional information						
4	Do You want to consider this Health policy for Portability## (YES / NO)						

#If claims in previous policy is "Yes", Please mention details of claim in 'INFORMATION ON HEALTH AND LIFESTYLE' section.

##In case you want portability of your previous policy, kindly fill the portability form separately.

V. Nominee Details*

Nominee Name	Nominee Relationship with Proposer	Nominee Contact Number
XXXXXXX	XXXXXXX	XXXXXXX

*Nominee details are mandatory

VA. Appointee Details (Required only if nominee is a minor)

Appointee Name	Relationship of Appointee with Nominee

Note - A Minor should not be declared as Appointee.
In the event of death of the Proposer, any payment due under the policy shall become payable to the nominee and the receipt of the proceeds by such nominee would be sufficient discharge to the Company.
For all other persons covered under the Policy, the Proposer will be the nominee.

VI. 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 reports, disability certificate from civil surgeon if any.

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
A. 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 or hospitalized for any one or more from the following? If YES then please mention Details in the additional information section below.						
1. Cancer, Tumor, Polyp or Cyst	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2. Any Heart Disease or Disorder, Chest Pain or Discomfort, Irregular Heartbeats, Palpitations or Heart Murmur	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Hypertension / High Blood Pressure (BP) / High Cholesterol / Any other Lipid disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Asthma / Tuberculosis (TB) / COPD / Pleural Effusion / Bronchitis / Emphysema or any other Disease of Lungs, Pleura and Airway or Respiratory Disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Thyroid Disease / Cushing's Disease / Parathyroid Disease / Addison's Disease / Pituitary Tumor / Disease or any other disorder of Endocrine System?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or Medication	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Motor Neuron Disease / Muscular Dystrophies / Myasthenia Gravis / Demyelinating Disease or any other Disease of Neuromuscular System (Muscles and / or Nervous System)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Stroke / Paralysis / Transient Ischemic Attack / Multiple Sclerosis / Epilepsy / Mental-Psychiatric Illness / Parkinsonism / Alzheimer's / Depression / Dementia or any other disease of Brain and Nervous System?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. Cirrhosis / Hepatitis / Wilson's Disease / Pancreatitis / Liver Disease / Crohn's Disease / Ulcerative Colitis / Inflammatory Bowel Diseases / Piles or any other Disease of Mouth, Esophagus, Liver, Gall bladder, Stomach or Intestines or any other part of Digestive System?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10. Kidney Stones / Renal Failure / Dialysis / Chronic Kidney Disease / Prostate Disease or any other Disease of Kidney, Urinary Tract or Reproductive Organs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11. HIV / SLE / Rheumatoid Arthiritis / Scleroderma / Sarcoidosis / Psoriasis / Bleeding or Clotting Disorders or any other Diseases of Blood, Bone Marrow / Immunity or Skin	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12. Disease or Disorder of Eye, Ear, Nose or Throat (except any sight related problems corrected by prescription lenses)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
13. Disease of the Musculoskeletal System / Or Thopedic Disorders / Degeneration, Fracture or Dislocation of Bones or Joints / Avascular Necrosis of Joints or any other Disorder related to it?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14. Any other Disease / Health Adversity / Injury / Condition / Treatment not mentioned above	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
15. Has any of the Proposed to be Insured been hospitalized / recommended to take investigations / medication or has been under any prolonged treatment / undergone surgery for any illness / injury other than for childbirth / minor injuries?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

16. Has any of the Proposed to be Insured have been suffering / suffered from Covid-19 disease? If yes, confirm if any complications arise due to Covid-19	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
17. Any of the Insured Persons is pregnant? If yes, please mention a. Expected Date of Delivery and b. Any complications/hospitalization regarding of pregnancy including high blood pressure, diabetes etc or any other	☐ Yes ☐ No a. _____ b. _____	☐ Yes ☐ No a. _____ b. _____	☐ Yes ☐ No a. _____ b. _____	☐ Yes ☐ No a. _____ b. _____	☐ Yes ☐ No a. _____ b. _____	☐ Yes ☐ No a. _____ b. _____
18. 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 / Glass of Wines] per week						
Smoking (Number of Cigarette / Bidi Sticks) per week						
Pan Masala / Gutkha (Number of Small Pouches) per week						
Any Other substance (Name & Quantity) per week						

Additional Information: Please attach extra sheets if required

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Disease Name						
Date of Diagnosis						
Last Consultation Date						
Name of Surgery (if any)						
Details of Treatment given (Hospitalization / OPD, other)						
Disability %						
Period of Hospitalization (if any)						
Any Other Information						

VII. Premium Payment Details

Mode of Premium Payment: ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Single

Payment By: Cash / Cheque / Demand Draft / Pay Order / Credit Card / Debit Card / ECS (NACH) / Reward Points / E-Wallet / UPI / Online / IMPS / NEFT / RTGS (Strike out whichever is not applicable)

Instrument Number	Instrument Date	Instrument Amount (INR)	Name of Premium Payer**	Relationship of Payer with Proposer	Bank Details (Bank Account Number, Bank Name, IFSC Code)

**** Income Tax benefit u/s 80D of Income Act,1961** 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, parents or parents-in-law). Eligibilities u/s 80D are subject to Income Tax Act,1961.

VIII. 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 _____

IFSC Code _____

Account Type (Current / Saving) _____

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

I agree and undertake to intimate in writing to Aditya Birla Health Insurance Co. Ltd. about any change in bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

Date _____ Place _____ Signature _____

ECS (NACH) Mandate:

☐ I would like to avail the renewal premium payment facility by mandating Aditya Birla Health Insurance Co. Ltd. to debit my premium through NACH.
For availing NACH, duly filled and signed physical NACH mandate to be submitted.
Note – You will be eligible for 2.5% renewal discount on the renewal premium, if the renewal premium is received through NACH / Standing instruction (where payment is made either by direct debit of bank account or credit card)

*Bank details are mandatory

IX. Vernacular Declaration

I hereby declare that I have fully explained the contents of the proposal form and all other documents incidental to availing the health insurance from Aditya Birla Health Insurance Co. Limited to the Proposer in the language understood by them. The same have been fully understood by them and the replies have been recorded as per the information provided by the Proposer. Replies have been read out to, fully understood and confirmed by the Proposer.

Declarant Name _____ Declarant Signature _____ Date _____

Proposer Name _____ Proposer Signature _____

Proposer Sign Date _____ Place _____

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 which includes sharing of my medical data through ABHA.

Declaration / Consent (AML / KYC):
"You agree that the Company shall be entitled to share and store any personal information and documents shared by you / for the purpose of AML / KYC compliance with its Vendors and partners for the purpose of validation and AML / KYC compliance and who can store and validate from the concerned authorities / agencies / portals. You also allow the Company to receive, maintain, save and store your AML / KYC related information and documents from third party entities / intermediaries for the purpose of AML / KYC compliance in regard to processing your application for insurance policy and / or its continuation, as the case may be in furtherance to the stipulated norms. In the event you have any concerns or you do not agree to the same, you are requested to kindly visit the nearest Company branch in regards to your Application / Proposal / Policy."

Date_____ Place _____ Signature _____



XA. Cookies

Aditya Birla Health Insurance uses the technology known as "cookies" to track usage patterns, traffic trends and user behaviour, as well as to record other information from the website. For certain services provided on this website, cookies allow Aditya Birla Health Insurance and / or its group companies / affiliates to save information locally so that you will not have to re-enter it the next time you visit. Many content adjustments and customer service improvements are made based on the data derived from cookies.

The information we collect from cookies will not be used to create profiles of users and will only be used in aggregate form.

The User may set their browser to refuse cookies. If the User so chooses, the User may still gain access to most of the Website, but the User may not be able to conduct certain types of transactions (such as shopping) or take advantage of some of the interactive elements offered.

If the User uses any of the sharing features that may be offered by this Site, the User's friend's email address will not be retained on Aditya Birla Health Insurance Website or used in any way by Aditya Birla Health Insurance Co. Ltd. or its group companies / affiliates.



XI. Insurance Advisor Report

Business Source Channel: ☐ Agency ☐ Corporate Agency ☐ Direct Sales ☐ Broker ☐ Other Channels	
Intermediary Details	
Intermediary Name	
Intermediary Code	
Ref Code 1	
Ref Code 2	
Relationship between Advisor and Proposer / Insured	
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 their favor pursuant to this Proposal Form 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 Proposer to the best of my knowledge.

Date

Signature of Agent

(Insurance Advisor Signed date cannot be prior to Customer's Signed date)

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.

XII. Annexure I - Optional Covers

Optional Covers:	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Note **1. Additional premium shall be applied for opting below Optional Covers** **2. For Optional Covers,** • In case of family floater, if opted it is applicable for all insured persons on floater basis. Individiual basis (this will depend on nature of optional cover opted). Please tick under Insured 1. • In case of Individual policy, applicable for the Insured person on individual basis who has chosen the Optional Cover.						
1. Reduction in Specific Disease Waiting Period ☐ 2 Years to 1 Year	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Reduction in Pre-Exiting Disease Waiting Period ☐ 3 Years to 2 Years ☐ 3 Years to 1 Year (This Optional Covers is not applicable for NXT Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Claim Protect (This Optional Cover is applicable for NXT Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Room Rent Type Options ☐ Option 1 - Single Private Room ☐ Option 2 - Shared Accommodation (This Optional Covers are not applicable for VIP and VIP+ Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Per Claim Deductible ☐ Option 1 - INR 15,000 ☐ Option 2 - INR 25,000 (This Optional Covers are not applicable for VIP and VIP+ Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Preferred Provider Network (PPN) Discount (This Optional Covers are not applicable for VIP and VIP+ Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Critical Illness Cover To select among the available options on Individual Basis ☐ 10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Personal Accident Cover (AD, PTD and PPD) To select among the available options on Individual Basis. Sum Insured ☐ 10 Lacs ☐ 15 Lacs, ☐ 20 Lacs, ☐ 25 Lacs, ☐ 50 Lacs Occupation (mandatory if Personal Accident Cover (AD, PTD) is opted)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. Super Credit (increases irrespective of claim) (This Optional Cover is applicable only for NXT Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10. Chronic Care (Day 1 In-Patient Hospitalization) Applicable for Listed Chronic Conditions: 1. Diabetes 2. Hypertension 3. Asthma 4. Hyperlipidemia 5. COPD 6. Obesity 7. Coronary Artery Disease (PTCA done prior to 1 Year) (This Optional Covers are applicable for MAX, NXT, MAX+, SAVR Plans)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

11. Chronic Management Program (OPD) (This Optional Covers are applicable for MAX, NXT, MAX+, SAVR Plans)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12. Cancer Booster i. Covers Pre and Post Hospitalization medical expenses ii. Covers Day Care Treatment upto Sum Insured (This Optional Covers are applicable for MAX, NXT, VIP, VIP+, MAX+, SAVR Plans)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
13. Durable equipment cover i. Ventilator | ii. Wheelchair | iii. Prosthetic Device iv. Suction Machine | v. Commode Chairs vi. Infusion Pump | vii. Oxygen Concentrator viii. Continuous Passive Motion Devices in case of Knee Replacement (This Optional Covers are applicable for MAX, NXT,VIP,VIP+ & SAVR Plans)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14. Chronic Care (Day 1 In-Patient Hospitalization) Restriction (This Optional Cover is applicable only for VYTL Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
15. Compassionate Visit	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
16. Second Medical Opinion for listed Major Illness	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
17. Annual Screening Package for Cancer Diagnosed Patients (INR 10,000 / Member / Policy Year)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
18. Annual Health Check-up (This Optional Cover is applicable only for NXT Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
19. Geographical Extension to include U.S. and Canada (This Optional Cover is applicable only for VIP Plan)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Occupation [mandatory if Personal Accident Cover (Optional Cover * is opted)]*						
Designation [mandatory if Personal Accident Cover (Optional Cover * is opted)]*						
Nature of duty [mandatory if Personal Accident Cover (Optional Cover * is opted)]*						
Whether Occupation requires significant Manual Labour / Hazardous Activities / Handling Hazardous Material / Explosives or Working at Height / with High Voltage or Maintenance of Law and Order? (Yes / No) [mandatory if Personal Accident Cover (Optional Cover * is opted)]*						

Aditya Birla Health Insurance Co. Limited
Product Name: Activ One, Product UIN: ADIHLIP24097V012324
1800 270 7000 | care.healthinsurance@adityabirlacapital.com | www.adityabirlahealthinsurance.com
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Registered Office:
9th Floor, Tower1, One World Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013.
CIN:U66000MH2015PLC263677
IRDA Registration No. 153

Acknowledgement (this is perforated section, to be placed & created accordingly)

Application Number _____

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