Health Insurance
Aditya Birla Health Insurance Co. Limited

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

Activ Secure - Proposal Form

Application No.:

1. Please select the appropriate options and fill the form in BLOCK LETTERS.
2. All details marked with(*) are mandatory.
The Proposer must authenticate the cancellations/ alterations in this form

Customer ID: _____ Branch Stamp:

I. Proposer Details:

Title*: ☐ Mr. ☐ Mrs. ☐ Ms. Gender*: ☐ Male ☐ Female 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 _____ Name and Relation _____

Email Id*

Identification Type* ☐ Aadhar Card ☐ PAN Card ☐ Passport ☐ Driving License

Others ☐ _____ Please mention ID Number _____

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)

GST Registration Status: ☐ Consumer ☐ Registered Dealer ☐ Compounding Dealer

Please specify GST Identity Number: _____ (mandatory for Registered dealer & Compounding dealer)

UPI Handle | Annual Income

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated

Education Qualification ☐ Graduate ☐ Under Graduate ☐ Others _____

Nationality* ☐ Indian ☐ Non Resident Indian ☐ Foreign National with Indian Origin ☐ Person of Indian Origin Others ☐ _____

II. Product/ Plan details

- **Personal Accident Cover** ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5 **(All members will have same plan)**

Optional covers available with Personal Accident Cover (Applicable for all members in the Policy except TTD) These covers are available with Sum Insured 5 Lacs and Above only.

a. ☐ Accidental in-patient hospitalization Cover
b. ☐ EMI Protect
c. ☐ Broken Bones Benefit ☐ 1Lac ☐ 3Lacs ☐ 5Lacs
d. ☐ Coma Benefit
e. ☐ Burn Benefit ☐ 1Lac ☐ 2Lacs ☐ 3Lacs
f. ☐ Adventure Sports Cover
g. ☐ Worldwide Emergency Assistance Services (including Air Ambulance)
h. ☐ Accidental Medical expenses
I. ☐ Loan Protect (Available with Sum Insured up to Rs.10 Crores only, Option may be chosen maximum upto Accidental Death Sum Insured)
j. Temporary Total Disability (TTD) ☐ Yes ☐ No (Limit max upto 2 times of Income, only for earning members)

- **Critical Illness Cover** ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 Optional Benefit: ☐ Second E-opinion

- **Cancer Secure Cover** ☐ Cancer Secure Optional Benefit: ☐ Second E-opinion

- **Hospital Cash Cover** ☐ Hospital Cash Cover

Limit per Year ☐ 30 days ☐ 45 days ☐ 60 days

- **Optional Cover** (Available across all plans)

Wellness Coach: ☐ Yes ☐ No

Policy Tenure*
(Discount applicable for 2 & 3 yr tenure)
☐ 1 year ☐ 2 years ☐ 3 years

Mode of Premium payment (Available for 1 year tenure policy only)*
☐ Monthly Installment ☐ Quarterly Installment
☐ Semi Annual Installment ☐ Single

III. Insured Details*:

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name*						
Relationship with Proposer*						
Date of Birth (DD/MM/YYYY)*						
Gender*						
Nationality*						
Height (cm) (not mandatory for Personal Accident)*						
Weight (kg) (not mandatory for Personal Accident)*						
Occupation (mandatory for Personal Accident)*						
Designation (mandatory for Personal Accident)*						
Nature of duty (mandatory for Personal Accident)*						
Annual Income (not mandatory for Hospital Cash)*						
Sum Insured for Personal Accident cover						
Limit for TTD (earning member only)						
EMI Protect Limit						
EMI (₹, mandatory if EMI protect is chosen)						
Loan Protect Limit						
Loan Account Number for Loan Protect (mandatory if loan protect is chosen)						
Loan Principal Outstanding (₹)						
Sum Insured for Critical Illness cover						
Sum Insured for Cancer Secure cover						
Hospital Cash Cover (Daily cash benefit)						

*Mandatory
Note: Discount applicable for Family Policy i.e. more than 2 persons covered under same Policy.

IV. Previous / Current Insurance Details:

Please fill the following details with respect to insurance policies(s) currently held with Us or any other insurance company.

	Previous/Current Insurance Details:	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1	Policy No./Application No.						
2	Type of Benefit covered (CI/PA/Cancer/HC/other health)						
3	Sum Insured (including bonus)						
4	Claim in previous policy (Yes/No)#						
5	Was any proposal declined, deferred, withdrawn or accepted with modified terms, if yes please provide details in additional information						
6	Do You want to consider this policy for Portability (Yes / No)##						

#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

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 the 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.

Personal Accident Cover

1 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)

Insured 1: Yes/No **Insured 2:** Yes/No **Insured 3:** Yes/No **Insured 4:** Yes/No **Insured 5:** Yes/No **Insured 6:** Yes/No

2 Have you ever been diagnosed with or consulted a doctor or advised surgery for any one or more of the following? Paralysis, Epilepsy/Fits, Physical disability/defects, Psychiatric disorder, defect in sight/hearing/speech. If yes, then please mention Disease name, disability %, Date of Diagnosis, Last Consultation Date, Name of Surgery (if any), Details of Treatment given (hospitalization/OPD) in the additional information section below.

Insured 1: Yes/No **Insured 2:** Yes/No **Insured 3:** Yes/No **Insured 4:** Yes/No **Insured 5:** Yes/No **Insured 6:** Yes/No

Critical Illness Cover and/or Cancer Secure Cover and/or Hospital Cash Cover

1. Have you ever been diagnosed with/advised to seek treatment or undergone any investigation or consulted a doctor or undergone/advised surgery for any one or more from the following? If YES then please mention Disease name, disability %, Date of Diagnosis, Last Consultation Date, Name of Surgery (if any), Details of Treatment given (hospitalization/OPD) in the additional information section below.

A
- Heart Disease, Peripheral Vascular Disease, procedures like Angioplasty/PTCA/Bypass Surgery,
- Diabetes, High blood pressure, High Cholesterol, Anaemia/Blood disorder
- Tuberculosis (TB), any Respiratory/Lung disease
- Disease of Eye, Ear, Nose, Throat, Thyroid, Paralysis, Polio
- Cancer, Tumour, lump, cyst, ulcer
- Disease of Kidney, Liver/Gall Bladder, Pancreas, Digestive tract, Breast, Reproductive/Urinary system, or complications of pregnancy
- Disease of the Brain/Spine/Nervous System, Epilepsy, Joints/Arthritis, Congenital/ Birth defect, Physical deformity/disability, HIV/AIDS, Sexually Transmitted Disease or Accidental injury or any other medical (other than common cold & viral fever) or surgical condition or Investigation findings beyond normal range?

Insured 1: Yes/No **Insured 2:** Yes/No **Insured 3:** Yes/No **Insured 4:** Yes/No **Insured 5:** Yes/No **Insured 6:** Yes/No

B Recurrent cough, hoarseness of voice, difficulty in swallowing for a continuous period of 15 days/ Persistent loss of blood/unusual discharge from any part of body/Unintentional Weight loss more than 5 kg within 6 months

Insured 1: Yes/No **Insured 2:** Yes/No **Insured 3:** Yes/No **Insured 4:** Yes/No **Insured 5:** Yes/No **Insured 6:** Yes/No

2. Have your Parents, brothers or sisters (below 60 years) had Heart disease/Stroke/Cancer/ Diabetes/Hypertension? If 'Yes', please mention the disease

Insured 1: Yes/No **Insured 2:** Yes/No **Insured 3:** Yes/No **Insured 4:** Yes/No **Insured 5:** Yes/No **Insured 6:** Yes/No

Name of the disease:_____

Do you consume any of the following substances? (if yes, pls mention quantity)

3. Alcohol [30ml (pegs) of hard liquor/bottles of beer/glass of wines] per Week.

Insured 1:_____ **Insured 2:**_____ **Insured 3:**_____ **Insured 4:**_____ **Insured 5:**_____ **Insured 6:**_____

4. Smoke (No. of Cigarette/bidi sticks) per Week

Insured 1:_____ **Insured 2:**_____ **Insured 3:**_____ **Insured 4:**_____ **Insured 5:**_____ **Insured 6:**_____

5. Pan Masala/Gutkha (No. of Pouches) per Week

Insured 1:_____ **Insured 2:**_____ **Insured 3:**_____ **Insured 4:**_____ **Insured 5:**_____ **Insured 6:**_____

6. Other (Name & Quantity) per Week

Insured 1:_____ **Insured 2:**_____ **Insured 3:**_____ **Insured 4:**_____ **Insured 5:**_____ **Insured 6:**_____

Additional Information: please attach extra sheets if required

Member Name	Cover Name	Details

VIII. Premium Payment Details*

Mode of Premium Payment

☐ Cash ☐ Cheque ☐ Demand Draft ☐ Pay Order ☐ Credit Card ☐ Debit Card
☐ Online ☐ E-wallet ☐ IMPS/ NEFT/ RTGS

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

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.

Please select any one of the below options as applicable.

☐ Bank account details as mentioned on the cheque being submitted along with the Proposal Form towards premium payment for insurance Policy should be used by the Company for electronic fund transfer as mode of payment.

Please fill the below table if the premium payment cheque does not have all the details required for electronic fund transfer.

☐ Bank account details as provided below and for which I am submitting a acceptable documentary evidence (cancelled cheque with Full Name Or latest Bank Passbook), should be used by the Company for electronic fund transfer as mode of payment. I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy.

Name as in Bank Account: _____

Bank Name: _____ Account Number: _____

Bank Branch: _____ IFSC Code: _____ MICR Code: _____

Bank City: _____

Account Type (Current/Saving): _____

I agree and undertake to intimate in writing to Aditya Birla Health Insurance Company 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:** _____

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.

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

XI. Authorization for electronic policy fulfillment and service communications

1) I hereby consent that the policy documents may be sent to me by email. Please tick

☐ Yes: If yes, Please provide us your e-mail id. _____ ☐ No:

2) 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.

☐ Yes ☐ No

XII. 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 Company to the Proposer in the language understood by him/her. The same have been fully understood by him/her 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 : _____

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 : _____

If applied, please mention your preferred Insurance Repository (IR):_____

Email id (Registered with Insurance Repository) : _____

Your Policy will be credited in your EIA account and your address details as mentioned in the EIA account shall override the address provided in this application for Insurance. We request you to inform the Repository of any changes in the details immediately

If No, do you want Us to create an EIA account for you: ☐ Yes ☐ No (if Yes, please fill up Insurance Repository Application Form)

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.

XIV. 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 ☐ Web Aggregator

Intermediary Details	
Intermediary Name	
Intermediary Code	
PAN / Aadhaar card number in case of POS Person	
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 including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein and that any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. 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 favour 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.

Date: _____

_____

Signature of Agent

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

Please use this section for disclosing any additional information. Please strike off this page in case not used.

ABHI/PROD/16-17/RFB/005

Aditya Birla Health Insurance Co. Limited. IRDAI Reg.153. CIN No. U66000MH2015PLC263677.
Product Name: Activ Secure, Product UIN: ADIHLIP18076V011718.
Address:- 10th Floor, R-Tech Park, Nirlon Compound, Next to HUB Mall, Off Western Express Highway, Goregaon East, Mumbai – 400 063. Website: adityabirlahealthinsurance.com,
Email: care.healthinsurance@adityabirlacapital.com, Telephone: 1800 270 7000, Fax: +91 22 6225 7700. For more details on risk factors, terms and conditions please read terms and conditions carefully before concluding a sale. Trademark/Logo Aditya Birla Capital is owned by Aditya Birla Management Corporation Private Limited and is used by Aditya Birla Health Insurance Co. Limited under licensed user agreement(s).

Contact us:
1800 270 7000

adityabirlacapital.com

ADITYA BIRLA CAPITAL

Please use this section for disclosing any additional information. Please strike off this page in case not used.

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XV. Acknowledgement for extra information

Proposer Name:_____ **Date:** _____ **Place:** _____

Signature: _____

XVI. 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

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 : _____