Health Insurance
Aditya Birla Health Insurance Co. Limited
(A subsidiary of Aditya Birla Capital Ltd.)

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

Global Health Secure Proposal Form

Application No. - Barcoded

1. Please select the appropriate options and fill the form in BLOCK LETTERS.
2. All details marked with* are mandatory.
3. Please disclose all facts and mention each information that may affect our decision to issue a policy or its price, terms, conditions, exclusions, truthfully and accurately as incorrect information may lead to policy cancellation/ claim rejection. The Policy shall become void at our discretion, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure of any material fact, particularly in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the proposer or any one acting on his behalf. If You are in any doubt, please seek the advice of your insurance advisor.
4. The Proposer must authenticate each cancellation/ alteration in this form

Customer ID: _____ Branch Stamp:

I. Proposer Details:

Gender*: ☐ Male ☐ Female ☐ Other 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
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	
Marital Status*	☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated
Nationality*	☐ Indian ☐ Non Resident Indian ☐ Foreign National with Indian Origin: <Nationality> ☐ Person of Indian Origin: <Nationality> ☐ Others:
Annual Income*	

☐ 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 2 and 3 year tenure)	☐ 1 Year ☐ 2 Years ☐ 3 Years	**Cover*:** ☐ Individual
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	
PED Waiting Period*	☐ 24 months ☐ 36 months ☐ 48 months	

III. Insured Details*:

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name*						
Relationship with Proposer*						
Gender*						
Date of Birth (DD/MM/YYYY)*						
Nationality* (This policy can be issued for benefit of Indian citizens residing in India (insured person). Cover is not allowed to NRIs, OCIs, PIOs or foreign nationals residing in India for employment.)	Indian Citizen and resident of India ☐ Yes ☐ No	Indian Citizen and resident of India ☐ Yes ☐ No	Indian Citizen and resident of India ☐ Yes ☐ No	Indian Citizen and resident of India ☐ Yes ☐ No	Indian Citizen and resident of India ☐ Yes ☐ No	Indian Citizen and resident of India ☐ Yes ☐ No
City of Residence*						
Height (cms)*						
Weight (kgs)*						
Email ID						
Mobile Number						
Sum Insured* (to be filled separately in case of Multi Individual policy)						
Suitable Date, time for Pre-policy check-up / Tele Verification (2 dates & time)						

(*) Mandatory.

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 or previously held with Us or any other insurance company.

S. No.	Previous / Current Insurance Details: *	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1.	Policy No. / Proposal No.						
2.	Insurer(s) Name(s)						
3.	Period of Insurance (From-To)						
4.	Sum Insured (in Rs.)						
5.	Claim in previous / current policy (Yes / No)#						
6.	Do You want to consider your existing international indemnity 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.
###Minimum base domestic (Indian) indemnity cover of Rs 10 lakh is mandatory to avail Global Health Secure.

Please confirm if you are having any active, base domestic (Indian) indemnity cover of at least Rs 10 lakh S.I. **which is not ported to or applied to port with us** - ☐ Yes ☐ No

S. No.	Particulars of current Health Insurance indemnity policy in India (in case of name of Insurer is Aditya Birla Health Insurance Co. Limited, then Sr No. 4, 5, 6, 7 are non-mandatory)^^	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1	Name of Insurer*						
2	Policy Name*						
3	Policy Number*						
4	Policy start date*						
5	Policy end date*						
6	Sum Insured*						
7	Claim in policy (Yes / No) and details of the same						

^^Attach policy schedule of existing domestic Health Insurance indemnity policy

V. Nominee Details*:

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the Nominee in accordance with the Policy terms and conditions. The Nominee must be an immediate relative of the Proposer.

Nominee Name	Nominee Relationship with Policyholder	Nominee Contact Number	Name and Contact of Guardian, in case the Nominee is a minor

VI. Assignment:

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

Relationship with the Assignee: _____

Reason for Assignment: _____

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	Insured 3	Insured 4	Insured 5	Insured 6
Cancer, Coronary Artery By-Pass surgery , Heart Valve Replacement, Major Organ damage / Transplantation, Bone Marrow Transplant, Neurosurgery, Pulmonary artery graft surgery, Aorta Graft Surgery, Myocardial Infraction, Stroke, benign Brain tumour, Lung Transplant Surgery, End Stage Lung Disease, Kidney Transplant Surgery, End Stage Renal Failure, Major Burns, Coma, Pheochromocytoma						
*Any form of Heart Disease other than listed above, Peripheral Vascular Disease, procedures like Angioplasty / PTCA.						
* 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						
*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?						
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						
Have your Parents, brothers or sisters (below 60 years) had Heart disease / Stroke / Cancer / Diabetes / Hypertension? If 'Yes', please mention the disease						
Was any proposal / policy for life, health, hospital daily cash, critical illness, cancer, personal accident insurance declined / deferred / withdrawn / 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

Name of person proposed to be insured	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: D D M M Y Y Y Y **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: D D M M Y Y Y Y Place: _____ Signature: _____

XI. 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: D D M M Y Y Y Y

Proposer Name: _____ Proposer Signature: _____

Proposer Sign Date: D D M M Y Y Y Y Place: _____

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 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: D D M M Y Y Y Y

_____

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.

Aditya Birla Health Insurance Co. Limited. IRDAI Reg.153. CIN No. U66000MH2015PLC263677.
Product Name: Global Health Secure, Product UIN: ADIHLIP21069V022021.
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. 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. 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 : D D M M Y Y Y Y