Health Recharge Proposal Form

602050002121

niva Bupa Health Insurance

URN: 011

1. Proposer Details:

Title Name

DOB (D D M M Y Y Y Y) Gender: Male Female Other Nationality

Current address

Landmark City

District State Pincode

Landline number Mobile number

Email ID Alternate number

Aadhaar Number (Optional) PAN Number

Annual income (Rs)

Employment Salaried Self-employed Student Housewife Other, please specify

Premium paid by Relationship with Proposer

Do You or any of the proposed applicants have an existing policy with Niva Bupa? Yes No

(If yes, please provide the policy number)

Are you or any of the proposed applicants a PEP#? Yes No

#Politically Exposed Persons (PEP) are individuals who are or have been entrusted with prominent public functions i.e. Heads / ministers of central or state government, senior politicians, senior government, judicial or military officials, senior executives of government companies, important party officials. (If you have ticked against PEP, kindly fill the separate PEP questionnaire)

Do you want the Physical Copy of the Policy Kit Yes No

Bank details:

Bank name

Account number IFSC Code

Account type Savings Current Branch City

Details of Electronic Insurance Account (eIA)

Do you wish to have this Policy credited to an e-Insurance account? (Please select any one)

No, I do not have an e-insurance account and do not wish to open one

Yes, credit this Policy to my e-Insurance account

If yes, Please share existing e-Insurance Account No.

Please select Insurance Repository Name (you have opened your account with)

1. NSDL 2. CIRL 3. KARVY 4. CAMS (Please select any one)

Or

I do not have existing e-Insurance account and I am interested in creating a new e-Insurance account (Please submit electronic insurance account opening form (eIA form) along with relevant documents).

2. Coverage Selection:

Are you applying for portability: ☐ Yes ☐ No (If "Yes", please fill the separate portability form also).

Please tick the relevant boxes:

Base coverage:

Lives to be covered: ☐ 1A ☐ 1A+1C ☐ 1A+2C ☐ 1A+3C ☐ 1A+4C ☐ 2A ☐ 2A+1C ☐ 2A+2C ☐ 2A+3C ☐ 2A+4C

Sum Insured: (Rs.) ☐ 2Lac ☐ 3Lac ☐ 4Lac ☐ 5Lac ☐ 7.5Lac ☐ 10Lac ☐ 15Lac ☐ 25Lac ☐ 40Lac ☐ 45Lac ☐ 65Lac ☐ 70Lac ☐ 90Lac ☐ 95Lac

Policy term: ☐ 1 Year ☐ 2 Years ☐ 3 Years

Deductible amount: Please mention the deductible amount chosen (Rs.): ☐☐☐☐☐☐☐☐

Optional coverage under the product:

a. Personal Accident Cover: ☐ Yes ☐ No

If yes, then please choose the lives to be covered: ☐ Primary Insured Person ☐ Primary Insured Person along with spouse

Are the lives to be covered under this optional benefit involved in a job or an occupation related to working as a staff in an aircraft or a sea going vessel, underground mining or tunneling, armed forces or security forces, participating in any adventure sports (including motor speed contests)? ☐ Yes ☐ No

Personal Accident Cover Sum Insured (Rs.): ☐☐☐☐☐☐☐☐

b. Critical Illness Cover: ☐ Yes ☐ No

If yes, then please choose the lives to be covered: ☐ Primary Insured Person ☐ Primary Insured Person along with spouse

Critical Illness Cover Sum Insured (Rs.): ☐☐☐☐☐☐☐☐

c. Modification in room rent: ☐ Yes ☐ No

(Note: This option is available only for Sum Insured up to Rs. 4 Lacs and deductible more than Rs. 50,000. By selecting this option, entitlement for the maximum room rent eligibility will be Single Private Room)

3. Details Of Applicants For Insurance:

Adult 1

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y Please tick if not Indian ☐

Relationship to Proposer (Please tick option): Self/Spouse/Son/Daughter-in-law/Daughter/Son-in-law/Father/Mother/Father-in-law/Mother-in-law/Grandfather/Grandmother/Grandson/Granddaughter/Brother/Sister/Sister-in-law/Brother-in-law/Nephew/Niece/Employer-Employee

Adult 2

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y

Relationship: Spouse of Adult 1 ☐ Please tick if not Indian ☐

Child 1

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y

Relationship: Son of Adult 1 ☐ Daughter of Adult 1 ☐ Please tick if not Indian ☐

Child 2

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y

Relationship: Son of Adult 1 ☐ Daughter of Adult 1 ☐ Please tick if not Indian ☐

Child 3

Name

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y

Relationship: Son of Adult 1 ☐ Daughter of Adult 1 ☐ Please tick if not Indian ☐

Child 4

Name

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y

Relationship: Son of Adult 1 ☐ Daughter of Adult 1 ☐ Please tick if not Indian ☐

4. Nomination

In the event of the death of the Proposer, any payment due under the Policy shall become payable to the Nominee named below. The receipt of such payment by the Nominee would constitute discharge of the Company's liability under the Policy. Nominee for all other applicant(s) shall be the proposer himself/herself.

Nominee Name	Date of Birth	Relationship with the Proposer	Address, mobile number and email ID of Nominee	Appointee Name (if nominee is less than 18 years of age)

Bank details of Nominee: Beneficiary Name:

Bank name Account type ☐ Savings ☐ Current

Account number IFSC Code

5. Medical and Habits Information

IMPORTANT: Please ensure that all the questions in this section are answered truthfully and completely as the information You provide here will form basis of underwriting by Niva Bupa. Please note any incomplete, incorrect, partially correct information may affect your claim and/or coverage.

SECTION A: Please share information on medical conditions

Please answer the following questions for each applicant. **Please circle Yes (Y) or No (N)**	Applicant Number											
	A1		A2		C1		C2		C3		C4	
i. Have you ever been hospitalized for more than 5 days, undergone / advised to undergo any surgical procedures, or taken any medication/ had any symptoms for more than 14 days? Medication is including but not limited to inhalers, injections, oral drugs and topical applications.	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ii. Have you ever had adverse findings to any diagnostic tests or investigations such as Thyroid Profile, Lipid Profile, Treadmill test, Angiography, Echocardiography, Endoscopy, Ultrasound, CT Scan, MRI, Biopsy and FNAC?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
iii. Do you have diabetes or high blood pressure?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
iv. Do you have any pre-existing diseases / conditions?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
v. Have you ever been diagnosed or treated for any genetic / hereditary disorders or HIV / AIDS?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
vi. Have you ever been diagnosed or treated for any mental/ psychiatric disorders?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

SECTION B: (Please fill this section only if the applicant smokes or consumes tobacco/ gutkha/ pan masala or alcohol)	Applicant Number					
	A1	A2	C1	C2	C3	C4
i. Chewable tobacco/Gutkha/Pan Masala - please specify number of pouches per day						
ii. Alcohol - please specify ml per week and/or Daily Drinker	☐ Daily Drinker	☐ Daily Drinker	☐ Daily Drinker	☐ Daily Drinker	☐ Daily Drinker	☐ Daily Drinker
iii. Cigarettes/Bidi/Cigar - please specify consumption per day						

SECTION C: For questions marked Yes (Y) in Section A, please specify following information:										
Applicant Number	Details of symptom(s) or investigation(s) or diagnosis or procedure / surgery undergone					Medication(s)	Dosage	Current status (e.g. Complete/ partial recovery or ongoing treatment)	Treating doctor's name & contact details	Documents attached (Yes/No)
	If Diabetes HbA1c Level	If High blood pressure BP Level		Any Other Details	Onset date (DD/MM/YYYY)					
		Systolic	Diastolic							

6. Past Proposals

Has any proposal for life, health, hospital daily cash, personal accident or critical illness insurance on the life of the Applicant ever been declined, postponed, loaded or subjected to any special conditions such as exclusions by any insurance company?	Applicant Number											
	A1		A2		C1		C2		C3		C4	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

7. Authorization for Electronic Policy fulfillment and Service Communications

Would you like to protect the environment and help save paper by authorizing the Company to send all your Policy and service related communication to the email ID as mentioned here in the application form? ☐ Yes ☐ No

8. Declaration (Please read carefully and put a check mark against each before signing the proposal form)

- ☐ 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/We authorize the Company to share information pertaining to my / our proposal including the medical records of the Insured / Proposer for the sole purpose of Service Delivery with our empaneled provider.

Date ☐☐☐☐☐☐☐☐ (D D M M Y Y Y Y) Place _____ Signature of the Proposer

9. Vernacular Declaration

(Certification in case the Proposer has signed in vernacular (to be witnessed by someone other than agent/ employee of the Company)).
The content of this form and its particulars have been explained by me in vernacular to the Proposer who has understood and confirmed the same:

Name of the certifying person:

Signature of the certifying person:

Mobile number of the certifying person: ☐☐☐☐☐☐☐☐☐☐

Name of the Witness

Signature of the Witness

Mobile number of the Witness: ☐☐☐☐☐☐☐☐☐☐

Signature of the Proposer

10. Proposer Declaration

(Certification where for any reason, the proposal and other connected papers are not filled in by the Proposer).
The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract. The Proposal Form is filled by _____ under my instruction and I found it to be correct.

Signature of the Proposer

11. Premium Details (for office use only)

Premium payment option ☐ Cheque ☐ Demand Draft ☐ Credit card ☐ Cash

Premium amount

Online payment transaction ID:

Date D D M M Y Y Y Y

Bank name/branch

Niva Bupa branch location

Code No.

Business sourced by:
Advisor/DST/Corporate Agency/Other Channels

Code No

Name

Proposal received on: D D M M Y Y Y Y

Customer ID:

Is Proposer or the applicant a staff? ☐ Yes ☐ No

12. Additional details for Bancassurance channel only (for office use only)

Branch Code SP Code

RM/LG code

Customer account number

13. Insurance advisor's report (for office use only)

1. Are you related to the Proposer? Yes/No; If yes, nature of relationship?
2. For how long have you known the Proposer? Years Months
3. Are you satisfied with the identity of the Proposer? ☐ Yes ☐ No
4. Does the Proposer or any applicant have any physical deformity/defect or mental retardation? ☐ Yes ☐ No
5. Have you explained the terms of the proposed policy, conditions for renewability, exclusions, waiting periods of the Policy and has the Proposer personally completed the health declaration? ☐ Yes ☐ No
6. Do you recommend acceptance of this proposal form considering all the factors including moral hazard? ☐ Yes ☐ No
7. Have you dispassionately advised the Proposer and provided all information to enable the Proposer to decide in the best cover that would be in his/her interest? ☐ Yes ☐ No

Date D D M M Y Y Y Y Signature of the Insurance Advisor

14. Statutory Warning

Prohibition of Rebates (Under Section 41 of the Insurance Act 1938)

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 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 published prospectuses or tables of the insurer.
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.

15. ABHA ID

Member Name	Do you have ABHA ID?	ABHA ID	Consent to share Medical records with insurers/TPA's through ABHA
	☐ Yes ☐ No	– – –	☐ Yes ☐ No
	☐ Yes ☐ No	– – –	☐ Yes ☐ No
	☐ Yes ☐ No	– – –	☐ Yes ☐ No
	☐ Yes ☐ No	– – –	☐ Yes ☐ No
	☐ Yes ☐ No	– – –	☐ Yes ☐ No
	☐ Yes ☐ No	– – –	☐ Yes ☐ No

16. Details for Refund & Payment of Claims

Option to receive payment: ☐ **Bank Transfer**

Name of the Beneficiary

Bank name

Account number IFSC Code

Account type

Niva Bupa Health Insurance Company Limited; Registered office:- C-98, First Floor, Lajpat Nagar, Part 1, New Delhi-110024

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Health Recharge
Key Feature Document (KFD)

Niva Bupa is dedicated to being fair and transparent with its customers. This document summarizes the key features of your Policy, however it does not replace your Policy contract and we encourage you to read all the details of your Policy before you conclude the purchase of this product.

Niva Bupa Health Recharge provides you with a range of benefits at a competitive price, ranging from hospitalization to multiple optional benefits like personal accident cover and critical illness cover, to better meet your needs.

You have to mandatorily choose an annual aggregate claim deductible amount in this Policy. Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the Deductible has been exhausted.

The following base benefits are provided, subject to some limits and exclusions as specified in the Policy contract:

- Inpatient care at a hospital, including room rent and ICU charges
- Pre and post hospitalization expenses for 60 and 90 days respectively
- Alternative Treatment
- Day Care Treatment
- Living organ transplant
- Domiciliary hospitalization
- Emergency ground ambulance
- Unlimited tele / online consultations
- Pharmacy and Diagnostic booking services
- Loyalty Additions (applicable only for Base Sum Insured <= Rs.25 Lacs): For each Policy Year, We offer an additional 5% of expiring Base sum insured up to at any time a maximum of 50% of base Sum Insured of that Policy Year. There will be no increase in sub-limits (if applicable) for any of the benefits.
- Expenses incurred for inpatient treatment for mental illness are covered under the policy up to Sum Insured subject to sub-limit for specific conditions as specified in the policy document.
- Expenses incurred for Hospitalization (including Day Care Treatment) due to condition caused by or associated with HIV / AIDS are covered under the policy.
- Artificial Life Maintenance.
- Modern treatments including oral chemotherapy, robotic surgeries etc. covered up to Sum Insured subject to sub-limits applicable on few treatments.

The following optional benefits are provided subject to some limits and exclusions as specified in your Policy:

- Personal accident coverage against accidental death, permanent total and partial disability
- Critical illness coverage for 20 major illnesses*.
- Room rent can be modified to single private room; covered up to Sum Insured (available only for deductible more than INR 50,000 and Sum Insured up to INR 4 Lacs)

Please note that an additional annual premium is charged for the optional benefits.

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Product Name: Health Recharge | Product UIN: NBHHLIP22156V032122

Note that waiting periods are applicable as per the Policy:

- Pre-existing Disease waiting period of 36 months since inception of the policy and subject to continuous renewal. For Critical Illness cover, pre-existing disease waiting period would be 36 months.
- Initial Waiting Period of 30 days unless the treatment needed is the result of an Accident. For Critical Illness cover, initial waiting period would be 90 days.
- Specific Waiting Period of 24 months, since the inception of the First Policy with us, for some listed illnesses, unless the condition is directly caused by Cancer (covered after Initial Waiting Period of 30 days) or an Accident (covered from day 1).
- Please note that Waiting Periods shall not apply to e-Consultation, Personal Accident Cover and Critical Illness Cover, unless mentioned otherwise.

Note that standards exclusions are applicable as set out in the Policy contract. In addition, based on the underwriting results, some specific exclusions or personal waiting period might also apply to your Policy.

Other key features of your Policy are as follows:

- Individual or family floater cover (up to 2 adults and 4 children), with any addition or deletion of member(s) in the Policy being done only at the time of renewal.
- **Lifelong renewability** of your Policy subject to your confirmation and timely payment of the due premium.
- **Your renewal premium will increase based on your age band but will not alter based on your claim experience. Renewal premium rates for the product may be revised in future subject to IRDAI approval and in accordance with the IRDAI's rules and regulations as applicable from time to time.**
- In case your proposal is declined for issuance, you will bear 100% of the cost incurred towards the cost of Pre Policy Medical Check-up (PPMC).

Notes:

Free look provision: If you do not agree to the terms and conditions of the policy, you may cancel the policy, stating your reasons within 15 days of receipt of the policy document provided no claims have been made under any benefits. The premium shall be refunded after deducting charges for medical check-up, stamp duty and proportionate risk premium for the cover period. The free look provision is not applicable at the time of renewal of the policy.

Premium: kindly deposit the premium amount through a secure mode of payment in the name of niva bupa health insurance company limited.

In case of any query or claim, please contact our Customer Helpline Number 1860-500-8888.

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

Renewal payment sign-up

Payment of renewal premium of your health insurance Policy can be made every year through continuing your existing Automated Clearing House (ACH) / Standing Instructions (SI) with the Company. Under this option, your Policy can be renewed promptly, but subject to you completing all additional requirements of information and documentation as may be required by the Company. This will ensure continuity of your policy benefits.

___I want to opt for the ACH/SI renewal option.

Date: _____ Signature of Proposer: _____

Place: _____ Name of Proposer: _____

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Acknowledgment By The Company

Application No. Date D D M M Y Y Y Y

We acknowledge with thanks the receipt of your proposal and amount by 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 made towards issuance of a Policy 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's 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 after deducting cost of medical tests, if any, received from you without interest.

Name and signature of the receiver and office seal

Product Name: Health Recharge | Product UIN: NBHHLIP22156V032122