PROPOSAL FORM

National Parivar Mediclaim Plus Policy

नेशनल इन्श्योरेन्स
National Insurance
Trusted Since 1906

Proposal for ☐ **New Policy** ☐ **Renewal (with change in details)**

Policy Period: From ☐☐☐☐☐☐ **midnight of** ☐☐☐☐☐☐
DD MM YY DD MM YY

IMPORTANT INSTRUCTIONS

(a) **This Proposal Form shall be the basis of the policy to be issued. It is therefore essential that all the information sought in this Proposal Form and all additional information relevant to the risk to be insured is provided fully & accurately. Please do not leave any space blank, or put dashes**
(b) **The Company will not be on risk until the Proposal have been accepted by the company and communication of the acceptance has been given to the proposer in writing after full payment of premium**
(c) **Details of up to 8 Insured Persons, including the proposer, can be filled in this Proposal Form. For additional members, please use a fresh form. Two stamp size photograph of each person are to be submitted, one of which is to be affixed on the Proposal form**
(d) **If opting for Optional Covers, please fill Section 9 of the Proposal Form.**
(e) **Persons 60 years of age and above or persons aged between eighteen years and sixty five years opting for the Critical Illness will have to submit pre policy checkup reports upto 1 month old and complete Annexure A**
(f) **Portability Form is provided in Annexure B.**
(g) **List of documents required is provided in Annexure C.**

FOR OFFICE USE ONLY

Premium (before discounts) :INR _____
Net Premium :INR _____

Intermediary_____
Code_____ Date_____/___/_____
Dev. Officer _____
Code_____ Date_____/___/_____

Risk acceptable: Y/ N
Competent Authority:
Name _____
Designation: _____
Signature_____
Policy No. _____
Issuing Office: _____
Office code: _____

1. PROPOSER DETAILS: Mr. ■ Ms■ Mrs. ■

Name: _____

Occupation/Business/Service/Other: _____ **PAN No:** _____

Aadhaar No: _____ **ABHA No:** _____

2. ADDRESS / CONTACT DETAILS:

Mobile No: _____ **Email ID:** _____

Present Address: _____

_____ **District:** _____ **State:** _____ **Pin:** _____

Permanent Address: _____

_____ **District:** _____ **State:** _____ **Pin:** _____

3. NOMINEE DETAILS:

Name of Nominee: _____ **Date of Birth:** dd / mm / yyyy

Relationship with proposer _____ **PAN no:** _____ **Mobile:** _____ **Email ID:** _____

Name of Guardian (if nominee is minor) _____ **Percentage of claim amount payable:** _____

Present Address: _____

_____ **District:** _____ **State:** _____ **Pin:** _____

Permanent Address: _____

_____ **District:** _____ **State:** _____ **Pin:** _____

4. POLICY DETAILS: (Please strike through the one not required)

Is TPA service required?: Yes | No

Premium paying Zone: Zone I | Zone II | Zone III | Zone IV **Policy duration:** 1 year | 2 years | 3 years

5. BANK DETAILS:

Name in Bank Account: _____

Bank: _____ **Branch:** _____

SB Account No: _____ **IFSC:** _____

6. INSURED PERSON DETAILS

No. of persons covered (including proposer) ……. (in figure), …… (in words)
Paste one stamp size photographs and sign below (In case of minor, guardian or proposer may sign):
(Another stamp size copy of the same photograph is to be submitted with this proposal form, with the proposer/ insured person's name written on the reverse)

Proposer	*Insured Person 1*	*Insured Person 2*	*Insured Person 3*	*Insured Person 4*	*Insured Person 5*	*Insured Person 6*	*Insured Person 7*

All the fields are mandatory. Please do not leave any field blank.

Customer Code								
	Proposer	**Insured Person 1**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**	**Insured Person 7**
Name								
Date of Birth (mm/dd/yyyy)								
Age								
Gender (M/F/TG)								
Height (cm)								
Weight (kg)								
Blood Group								
Marital Status								
Relationship with Proposer								
Dependent (Y/N)								
Occupation								
Floater Sum Insured								
Do you smoke? (Y/N)								
Do you drink alcohol? (Y/N)								

SI available are ₹ 1/ 2/ 3/ 4/ 5/ 6/ 7/ 8/ 9 /10 Lac per familiy

7. INSURANCE PARTICULARS

Is there an active Base Policy covering any/ all of the insured persons for hospitalisation? Yes/ No
If yes, please give details below and attach policy copies

Policy No.	**Insurer**	**Floater/ Ind**	**Members covered with SI and CB**	**Policy Name**	**Expiry Date**	**Last Claimed Date**	**Claimed Amount**	**Porting? (Y/ N)**

8. EXISTING DISEASES OF PROPOSER AND INSURED PERSON

If Proposer/ any Insured Person is/ are diagnosed with any condition, ailment, injury or disease by a physician any time prior to the date of Proposal or for which medical advice or treatment was recommended by, received from or is being received from a physician, complete the following table with date of diagnosis. Please do not leave the spaces blank.

Existing Diseases,

Disease Name	Proposer	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7
Sarcoidosis								
Malignant Neoplasms								
Epilepsy								
Heart Ailment, Congenital heart disease and valvular heart disease								
Cerebrovascular disease (Stroke)								
Inflammatory Bowel Diseases								
Chronic Liver diseases								
Pancreatic diseases								
Chronic Kidney disease								
Hepatitis B								
Alzheimer's Disease, Parkinson's Disease								
Demyelinating disease								
Loss of Hearing								
Papulosquamous disorder of the skin								
Avascular necrosis (osteonecrosis)								
Any other diseases?								

Above PEDs will be covered after a waiting period of 3 years from inception of Policy.

9. OPTIONAL COVERS

	Proposer	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7	How to opt?
Diabetes									Write 'Yes' if required. Cover available up to SI graded year wise
Hypertension									Write 'Yes' if required. Cover available up to SI graded year wise
Outpatient Treatment									Write Limit of Cover required. Available limits per family: INR 2,000/ 3,000/ 4,000/ 5,000/ 10,000/ 15,000/ 20,000/ 25,000
Critical Illness									Write Benefit Amount required per individual. Available amount: INR 2,00,000/ 3,00,000/ 5,00,000/ 10,00,000/ 15,00,000/ 20,00,000/ 25,00,000 per individual

Critical Illness benefit amount should not be more than the sum insured opted under the Policy

10. PAYMENT DETAILS

Premium Paid by: ☐ Cash ☐ Cheque ☐ DD ☐ Others, specify _____

Amount_____ Date_____/_____/_____Bank Name _____

11. DECLARATIONS

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 respect. I consent and authorize the Insurers to I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured to the best of my knowledge and that I am authorised to propose on behalf of these other persons.

I understand that the information provided by me will form the basis of the insurance policy, and that the policy will come into force only after receipt of the premium chargeable.

I further declare that I/we will notify in writing any change occurring in the occupation or general health of the 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 from a 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 proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority.

If any of the above statements, answers and/or particulars given by me are found to be incorrect any time during the currency of the Policy, it shall be considered as violation of disclosure of information and the Policy shall be void and all premium paid thereon shall be forfeited to the Company.

Place: _____ **_____**

Date: _____ **Signature of the proposer**

CERTIFICATE FROM PROPOSER

The proposal form is filled up by my representative, but the contents of the documents have been fully explained to me and I am willing to accept the coverage subject to terms, conditions and exceptions prescribed by the Insurance Company therein.

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

Name of the Proposer (in BLOCK LETTERS) _____
N.B. : This should necessarily be signed by proposer, or by his/her representative if Proposer is a person with disability.

12. SECTION 41 OF INSURANCE ACT, 1938 – PROHIBITION OF REBATES (Amended as per The Insurance Laws (Amendment) Act, 2015

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 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 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.**

Annexure A

MEDICAL EXAMINATION REPORT **PART I:** **PERSONAL HISTORY**

To be completed by consulting physician / surgeon in case of adverse medical history

1	**Name of the Insured Person**	**:**
2	**History**	
(a)	**Present complaints and investigation, if any**	**:**
(b)	**Any past history of disease, operations, accidents, investigations with date, major medical complaints of hospitalisation?**	**:**
(c)	**Details of present and past medication with duration**	**:**
(d)	**Is he cured of diseases, if any?**	**:**
	When was your treatment, if any, given, stopped?	**:**
3	**General examination**	**:**
4	**Systematic examination**	**:**

Name of Medical Examiner & qualification:
Regd. No:
Address: **Signature of Medical Examiner:**

Date: **Signature of Proposer:**

Annexure B

Policy No. :
Name of Insured Person:

To be completed by the insured in case of porting from a health insurance policy issued by another insurance company

Portability Form

1)	Name of the Policyholder / insured (s)	
2)	Date of Birth/Age	
3)	Address of the policyholder/insured	
4)	Details of existing insurer	
	i. Name of insurance company	
	ii. Name of the product	
	iii. Sum Insured	
	iv. Cumulative Bonus	
	v. Add-ons/riders taken	
	vi. Policy number	
5)	Details of the proposed insurance	
	i. Name of the product proposed/intend to take	
	ii. Sum Insured Proposed	
	iii. Whether Cumulative Bonus to be converted to an enhanced sum insured	
6)	Reason(s) for Portability	
7)	No. of family members to be included in the policy to be ported	
Enclosure: Photocopy of the existing & previous policy documents		
Date: Signature of the policyholder		

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy? (Please indicate Yes / NO):

2. If yes, please give written consent to the declaration below:

I am aware that the waiting period for the following disease(s)/treatment(s) is more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s).

Name of disease/ treatment	Waiting period in days/ years
1. 2. 3. 4.	

Place :

Date :

_____

Signature of the policyholder

Documents required

1. Completed proposal form
2. Cancelled cheque (supporting bank account details)
3. Stamp size photograph (1 nos) for each insured person
4. Pre policy check up reports (if applicable)
5. Copy of existing health insurance policies (if applicable)
6. Proof of identity (any one document listed below)
7. Proof of residence (any one document listed below)
8. Copy of IT Certificate/ IT Return (wherever applicable)
9. Pan Details (in case PAN not available, Form 60 or 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted)

Documentary proof

Features	Documents
Proof of identity	i. Passport ii. PAN Card iii. Voter's Identity Card iv. Driving License v. Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer vi. Personal identification and certification of the employees of the insurer for identity of the prospective policyholder. vii. Letter issued by Unique Identification Authority of India containing details of name, address and Aadhar number viii. Job card issued by NREGA duly signed by an officer of the State Government
Proof of Residence	i. Telephone bill pertaining to any kind of telephone connection like, mobile, landline, wireless, etc. provided it is not older than six months from the date of insurance contract ii. Current Passbook with details of permanent/present residence address (updated upto the previous month) iii. Current statement of bank account with details of permanent/present residence address (as downloaded) iv. Letter from any recognized public authority v. Electricity bill vi. Ration card vii. Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof viii. Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)
Proofs of both Identity and Residence	Written confirmation from the banks where the proposer is a customer, regarding identification and proof of residence.