THE ORIENTAL INSURANCE COMPANY LIMITED

Regd. Office: Oriental House, A-25/27, Asaf Ali Road, New Delhi-110002.
CIN No.U66010DL1947GOI007158

ORIENTAL SAMPOORNA SWASTHYA SURAKSHA

WE VALUE YOUR HEALTH & YOUR WEALTH. BUILD A PRODUCTIVE NATION

PROPOSAL FORM

i. PROPOSAL FORM AND SELF DECLARATION FORM TO BE FILLED IN BLOCK LETTERS AND IN UPLICATE.
ii. PLEASE ATTACH TWO STAMP SIZE PHOTOGRAPHS OF EACH PERSON PROPOSED TO BE INSURED
iii. THE COMPANY WILL NOT BE ON RISK UNTIL THE PROPOSAL HAS BEEN ACCEPTED BY THE COMPANY AND COMMUNICATION OF THE ACCEPTANCE HAS BEEN MADE TO THE PROPOSER IN WRITING ON RECEIVING FULL PAYMENT OF PREMIUM.

1. NAME OF THE PROPOSER: Mr. / Mrs. / Miss:

2. NAME OF THE INSURED PERSON AND RELATIONSHIP WITH THE PROPOSER

SL. NO.	Name of Insured Person	Relationship With proposer	Gender M/F/TG*	Dependent on proposer Y/N	Date of Birth	Age in completed years	Occupation
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

3. ABHA NO./IF NOT DO U WANT TO CREATE: _____

4. PRESENT ADDRESS & TELEPHONE NO. / MOBILE NO. / E-MAIL ADDRESS OF PROPOSER

												Mobile No.												
Phone No.																								
Email ID																								

5. PERMANENT ADDRESS & ALTERNATE TELEPHONE NO. / MOBILE NO. / E-MAIL ADDRESS OF PROPOSER

											Mobile No.												
Phone No.																							
Email ID																							

6. PLAN OPTED:

PLAN (PREMIUM/ELITE/ROYAL)	SUM INSURED OPTED UNDER THE PLAN (Rs. In lacs)

7. OPTIONAL COVERS:

A. PERSONAL ACCIDENT COVER

S. NO.	NAME	SUM INSURED (RS. IN LAKHS)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

B. PED WAITING PERIOD REMOVAL OPTION:

PED BUY BACK OPTION/PLAN		
PREMIUM		**YES / NO**
3 years to 2 years	20%	
3 years to 1 years	30%	
3 years to 0 years	50%	
ELITE		**YES / NO**
2 years to 1 years	20%	
2 years to 0 years	30%	
ROYAL		**YES / NO**
2 years to 1 years	20%	
2 years to 0 years	30%	
1 year to 0 years	30%	

C . **CO-PAY WITH FIXED AMOUNT:**

Select Option For Co-Pay with fixed amount

Sum Insured	Option 1	Yes/No	Option 2	Yes/No
100000	7500		15000	
200000	10000		20000	
300000	10000		20000	
400000	15000		30000	
500000	15000		30000	
600000	15000		30000	
700000	20000		30000	
800000	20000		30000	
900000	20000		30000	
1000000	20000		30000	
1200000	20000		40000	
1500000	20000		40000	
1800000	20000		40000	
2000000	20000		40000	
2500000	25000		50000	
3000000	25000		50000	
4000000	25000		50000	
5000000	25000		50000	

D. **ROOM RENT UPGRADATION** :

ROOM RENT UPGRADATION CLAUSE	
PREMIUN PLAN	50%
	100%
ELITE PLAN	50%
	100%

7. Bank Account Details:

i. Name of the A/c Holder	
ii. Name of the Bank	
iii. A/c No.	
iv. IFSC Code	

8 .PERMANENT ACCOUNT NO. (ISSUED BY INCOME-TAX AUTHORITIES)

9. NAME - ADDRESS & TELEPHONE NO OF FAMILY PHYSICIAN

Phone No.											Mobile No.												

10. MONTHLY INCOME: ----------

11. PEASE GIVE THE DETAILS OF ANY HOSPITALISATION / ILLNESS/DISEASE/INJURY AT PRESENT OR IN THE PAST 4 YEARS. (Whether or not insurance existed)

12. **HAS THE PROPOSER OR ANY OF THE MEMBERS OF THE FAMILY PROPOSED BEEN REFUSED INSURANCE FOR HEALTH COVER / POLICY CANCELLED / RENEWAL DENIED. IF SO DETAILS THEREOF**:

S.No	Name of the Proposed person	Refusal by insurer & reasons thereof	Cancellation of policy / denial of renewal by the insurer & reasons thereof

13. Do you wish to opt out of TPA Service?

YES	NO

9. PROPOSED DATE & PERIOD OF INSURANCE (DD MM YYYY)

FROM									TO								

TIME (24 HOURS):

DECLARATIONS:

1. 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.
2. 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.
3. 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.
4. I declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority.

Place:		Signature of Proposer:
Date:		Name of Proposer:_____

NOTE: In case of death claims, the name of the beneficiary making claim, relationship with the insured and legal status is to be mentioned.
The claim for any of the insured person will be payable in the name of Proposer and discharge voucher signed by him will be considered valid. However, in the event of unfortunate demise of the Proposer during the course of policy period, the claim may be payable to the nominee declared by the Proposer in this form.

Nomination:

In the event of my death, I nominate ..... (Please give details as per table below) in respect of the amount payable by the Oriental Insurance Company Ltd under this policy and I further declare that his receipt shall be sufficient discharge to the Company.
Dated this.....Day of.....200.....at.....

S. No.	Name of Nominee	Date of Birth	Mobile No.	Email ID	Present Address	Permanent Address	Relationship	Authorized Person (if nominee is a minor)	Nominee's Bank A/c Holder Name	Bank Name	Account No.	IFSC Code	Nomination %
1													
2*(if any)*													
3*(if any)*													

NOTE:

i Authorized Person column is only applicable if the nominee is a minor.

ii Make sure the Nomination Percentage across all rows totals to 100%.

Signature of Proposer

Signature of Witness:

Name and address:

PLEASE NOTE:

In case there is a change in any of the information already provided in the proposal form like mobile number, email IDs, residential address, bank account details, and nominee details during the term of the policy, please update such information, to enable for providing efficient policy servicing.

PROHIBITION OF REBATES (Section 41 of the Insurance Act 1938 provides)

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 anyperson taking out or renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus 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.

VERNACULAR DECLARATION:

(The Company requires that this proposal is completed by the proposer himself. However, if this is not possible as the proposer does not read, write or speak English, then this proposal form can be completed by another person who can read, speak and write English and who is not connected to the company either as an agent/employee or Insurance
Intermediary)

I have explained the contents of this proposal to the proposer and done my best to ensure that the contents have been fully understood by the proposer. I have accurately recorded the proposer's responses to the information sought by the proposal form and I have read the responses back to the proposer and he/she has confirmed that they are correct.

Name of the Witness:

Signature of the Witness

Date:

Thumb Impression/Signature of the Proposer:

AGENT DECLARATION: I, in my capacity as an Agent/ Insurance Advisor/ Specified Person of the Corporate Agent/ Authorized 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 or 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, the Company shall have the right to cancel the policy at its discretion. Further, this declaration does not confirm issuance of policy or assumption of risk thereof.

.Name of the Agent:

Date: Place:

Agent Code: Signature of the Agent…….

SELF DECLARATION FORM

(FORM TO BE DULY FILLED & SIGNED BY EACH PROPOSED PERSON, IN DUPLICATE)

Personal Details:

1. Name of the Insured: _____
2. Age (in completed years):_____
3. Date of birth:_____
4. Sex: _____
4. Address: _____
   _____
5. Telephone No.:_____6. E-mail ID: _____

Identification Document Details: (Photo ID Proof / Ration Card):

A) PERSONAL HISTORY (For all insured persons listed in the proposal)

	PARTICULARS	YES/NO	DETAILS
A	Are you in good health and free from physical and mental diseases or infirmity or major complaints?		
B	Have you ever suffered from any of the following diseases / illnesses? Please write Yes / No.		
1	Any Neurological / mental or related diseases?		
2	Slipped disc or other spinal disorder or paralysis of any kind or fainting episode, blackout, fit.		
3	High blood pressure, palpitation, Heart diseases including ischaemic heart diseases, other circulatory disorders including rheumatic fever etc.		
4	Diseases of uterus, ovaries, breast or any other gynaecological disorder		
5	Fistula, Piles, Hernia, Varicose veins etc.		
6	Any disease of bones, joints, Arthritis including rheumatic diseases etc.		
7	Any respiratory diseases		
8	Any allergic diseases		
9	Any dimness of vision or cataract etc.		
10	Any disease of ears or difficulty or interference with hearing etc.		
11	Any disorder of the stomach, ulcer, bowel or gall bladder, kidney etc.		
12	Cancer, malignant growth, boil, cyst or wound etc.		
13	Diabetes or any urinary diseases.		
14	Genetic oder		
15	Any cerebral or vascular strokes or sudden loss of consciousness or similar disease.		
16	Tuberculosis (TB)		
17	AIDS / HIV / related disorder etc.		
18	Congenital diseases (Since Birth)		
19	(a) Have you ever suffered from dental problems		
	(b) If, yes, specify same.		
	(c) When were you treated last for same?		
20	Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations.		
21	Any other complaint or tendency that may necessitate such consultation or treatment in the future		

B) Have you noticed sudden decrease or increase in your weight in past six months? Yes / No

C) Have you visited a doctor /hospital /healthcare unit for evaluation or treatment in recent past? If yes, give details:_

_____

D) Please furnish details of any Hospitalization / Pre-existing Disease/ Illness suffered / contracted in the past four Years. Give all Details.(Attach Copy of discharge card and doctors consultation notes and investigations copy):

E) **Past surgical details**:

Name of surgery or part operated:

Date of operation:

Completely cured YES / NO, give details: _____

(Attach Copy of discharge card and doctor's consultation notes and investigations copy)

1. I the Undersigned hereby declare that all the information given by me in this form is true and I understand that any of these details if found untrue on correlation with my medical test or medical examination before or after issuance of policy will affect the coverage and payments of my health insurance benefit under this Mediclaim policy.

2. I do hereby solemnly declare that all Pre-existing diseases have been declared and explicit information of such disease given in the above columns where the information has been sought.

3. I, give consent that if any of the pre- exiting disease declared by me, falls under the list of diseases given under "Clause 5" of the Prospectus /Policy document, the specific ICD codes for that particular disease mentioned therein, will be permanently excluded from the policy coverage.

Signature:

Name of the person proposed to be insured:

Date: Place: