THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI - 400 001.

PROPOSAL FORM FOR JANATA MEDICLAIM POLICY

Please read the prospectus before filling up this form.

A) The Company shall not be on risk until the proposal has been accepted by the Company and communications of acceptance has been given to the proposer in writing on full payment of premium.

B) For persons above 45 years of age or persons below 45 years of age, having adverse medical history declared in the proposal form will have to undergo, pre-acceptance health check up at a designated hospital/nursing home. The Divisional Office/Branch Office in the name of hospital/Nursing home will give a referral slip for conducting the pre-acceptance health check up. The details of the check up to be done are available with the Divisional Office/Branch Office.

C) If other family members residing with proposer i.e. spouse, eligible dependent children and dependent parents and dependent parents in law are required to be covered, complete details of each person should be furnished. Two Stamp size photograph of each person are to be submitted, one of which is to be affixed on the proposal.

D) Fresh proposal form is required along with pre acceptance medical check up as mentioned in item (B) above, irrespective of age, when there is break in insurance cover or when there is request for enhancement in the sum insured.

E) Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy.

1. NAME OF PROPOSER : Mr./Mrs._____

2. RESIDENTIAL ADDRESS : _____

   _____

   Tel. No. :_____ Fax No. :_____

   E-Mail :_____

3. Occupation: (please Tick)

   - ❑ Professional/Administrative/Managerial
   - ❑ Business /Traders
   - ❑ Clerical, Supervisory and related workers
   - ❑ Hospitality and Support Workers
   - ❑ Production Workers, Skilled and non-Agricultural Labourers
   - ❑ Farmers and Agricultural Workers
   - ❑ Police/Para Military/Defence
   - ❑ Housewives
   - ❑ Retired Persons
   - ❑ Students - School and College
   - ❑ Any Other

4. Average Monthly Income Rs._____Income Tax PAN No.:_____

5. NAME, ADDRESS & TEL. NO. : OF FAMILY PHYSICIAN _____

_____

QUALIFICATION :_____REGN. NO :_____

6. Are you a member of Recognized Health Club/Gymnasium:

If yes, then submit proof of your membership _____

7. Are you at present or have you been at any other time in the past covered under any other Insurance (PA, Cancer Insurance, Hospitalization Insurance or other Medical Insurance). If so, give particulars of:

Content	Details
Name of Insurer	
Insurance Scheme	
Policy No.	
Period of cover	
Claim Amt. Recd./receivable	

8. Any proposal for this Insurance or any other similar insurance refused or cancelled or higher premium charged. If so, give details:

9. DETAILS OF PERSONS TO BE INSURED:

Sr. No.	Name of all the persons	Date of Birth	Age	Sex (M/F)	Relation with the Proposer	Sum Insured selected	History of (Pl s. Tick)	
							Diabetes	Hyper tension
1								
2								
3								
4								
5								
6								

10. Nominee Details

Sr. No.	NAME	Relation	Date of Birth	Appointee Name* (If the Nominee is minor)	Relationship with Minor (Nominee)	% Share nominee is entitled to*

***Note- If only one nominee is mentioned insurer will consider his share is 100%**

11. Please Tick ☐ if you wish to receive the physical copy.

    By Default Policy documents shall be shared to your Registered Email ID.

12. **MEDICAL HISTORY:** Please answer the following questions with Yes or No (A dash is not sufficient and give full details in respect of all the persons to be insured)

    1) Are all the members proposed for insurance in good health and free from physical and Mental disease or infirmity? If no, give details of the illnesses/ diseases for each member. Select the illness/conditions from the table given below:

Sr. No.	Name of the Person	Nature of illness / pre-existing diseases (*)

*Table for selecting Pre-Existing Disease (PED)

Ischaemic Heart Disease	Hypertension	Diabetes Mellitus
Spinal or Vertebral Disorders	Cataract	Breathing Disorders
Uterine Bleeding	Arthritis and Joint disorders	Gastritis and Duodenitis
Kidney disorders	Headache Syndromes	Hernia
Stroke and T.I.A.	Thyroid and Other Hormonal Disorders	E.N.T. Disorders
Cholelithiasis	Any Malignancy	Hemorrhoids
Enlargement of Prostate (BPH, enlargement of prostate)	Any Other (Please specify)	

    2) Has any of the persons proposed for insurance has suffered from any illness/disease or had an accident in **the past?** If so, give details as under:

Name of the person	Nature of Illness / disease / injury & treatment received (please refer)	Date on which first treatment taken	First treatment completed/ is continuing	Name of attending medical practitioner / surgeon with his address & Tel.Nos.

Note: This information should be given for any of the persons proposed for insurance, if

he/she had suffered from any illness/disease injury, please give details separately.

13. ABHA NUMBER/ABHA ID*#

Member name	ABHA Number (14 digits)	Consent to share Medical records with Insurers / TPA's through ABHA
		☐ YES / ☐ NO
		☐ YES / ☐ NO
		☐ YES / ☐ NO
		☐ YES / ☐ NO
		☐ YES / ☐ NO
		☐ YES / ☐ NO

 # Note-Disclosing the ABHA ID in this form will not absolve the Proposer/Members from Disclosure of all Material Facts relating to this Insurance.

***Ayushman Bharat Health Account (ABHA) Declaration :** I/We provide my/ our consent to access my/ our (all insured) medical and personal records/ details, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider/s of **The New India Assurance Company Ltd** and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations.

3) Are there any additional facts affecting the proposed Insurance, which should be disclosed to insurers? If yes, then give details below:

4) Please give details of any knowledge or any positive existence or presence of any ailment, sickness or injury, which may require medical attention? If yes, then give details below:

5) Period of Insurance : From_____To _____

6) **Declaration:** I declare that the persons proposed for insurance are my family members and they are not engaged in high risk occupation. I also declare that none of them suffer from any pre-existing conditions and that I have given explicit information of such sickness/disease/injury sustained in the above columns where the information has been sought. I further declare that the above statements in respect of myself and my family members, are true and complete. I consent and authorize the insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended me or my family members or may attend concerning any disease or illness which affects my or my family members, physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be affected. If after the insurance is affected, it is found that the statements, answers or particulars stated in the Proposal form and its Questionnaires are incorrect or untrue in any respect, the Insurance Company shall incur no liability under this insurance.

Photographs of Insured Persons:

Proposer	1	2	3	4	5
Proposer	1	2	3	4	5

Signature of Proposer _____

Date :_____/_____/_____ Place: _____

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 of 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 except any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the insurer.

2) Any person making default in complying with the provisions of this Section shall be punishable with fine, which may extend to ten lakh rupees.

FOR OFFICE USE ONLY:

Sr. No.	Name ofinsured person	Date of Birth/ Age	S.I. (Rs.)	Loading for diabetes and hypertension	Discounts, If any	Premium
1						
2						
3						
4						
5						
6						
Remarks of Underwriter:				**Total:**		
				GST		
				Gross Total		

NEFT 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.

I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy:

Bank account details as provided below and for which I am submitting a cancelled cheque, should be used by the company for electronic fund transfer as mode of payment.(cancelled cheque should be of the same bank account in which the refund needs to be credited directly)

Particulars of Bank account:

Name(As in Bank Account)	
Name of the Bank	
Name of Branch	
Bank Account Number	
MICR No	
IFSC Code	

I agree and undertake to initiate in writing to **The New India Assurance Company Ltd** about any change in the bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

Proposer/Policy holder's signature:

Date:

DISCLAIMER: **The New India Assurance Company Ltd.** Shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation – failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder.

Aforesaid NEFT transactions shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. **The New India Assurance Company Ltd** shall be indemnified against any loss/damages/claims caused to **The New India Assurance Company Ltd** in carrying out your aforesaid NEFT instructions.

Instructions

- It is important for these electronic payment systems that the policy Holder's name in the Policy must be exactly match with the name in the Bank Account records/details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required
- The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFSC Code, which is applicable to NEFT only.(a number allotted to each participating bank branch) of the branch where the funds need to be transferred.
- Cancelled cheque should be attached along with the NEFT format.
- In case of cancelled bank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required.
- NEFT Form needs complete in all respect.