

Please fill up this form in CAPITAL LETTERS for yourself and each proposed insured person.

1. Proposer Details

Name

Permanent Address

City District

State Pin code

Current Address

City District

State Pin code

Address for Communication Permanent Current

Phone No. STD Code Landline No. Mobile No.

e-mail ID

PAN No. (Mandatory for premium above Rupees one lac)

Marital Status Single Married Divorced Widow(er) Separated

Nationality

Educational Qualification Lesser than matriculation Matriculation Graduate Post-graduate Professional Course

Occupation Salaried Self employed Student Housewife Others

If salaried, specify designation

If self employed, specify business/occupation

Annual Gross Income (in Rs.)

Bank Details:

Bank Name

Branch

City

Account Number

Account Type Savings Current

Coverage Selection: Section I

1. Plan details

Policy Type Individual Family Floater Family First

If Family Floater, number of persons to be covered 2 Adults + 2 Children 2 Adults + 1 Child 2 Adults
 1 Adult + 1 Child 1 Adult + 2 Children

If Family First, number of person to be covered Adults _____ Children _____ Please tick/fill the relevant boxes.

2. Proposed policy term (2 year policy term available only for individual and Family Floater plans)

1 year 2 year

3. Sum Assured (in Rupees)

a. Individual/Family Floater:	Silver		Gold			Platinum		
	<input type="checkbox"/> 2 Lacs	<input type="checkbox"/> 3 Lacs	<input type="checkbox"/> 5 Lacs	<input type="checkbox"/> 7.5 Lacs	<input type="checkbox"/> 10 Lacs	<input type="checkbox"/> 15 Lacs	<input type="checkbox"/> 20 Lacs	<input type="checkbox"/> 50 Lacs
b. Family First:		<input type="checkbox"/> Silver	<input type="checkbox"/> Gold					
• Individual Sum Insured:		<input type="checkbox"/> 1 Lac	<input type="checkbox"/> 2 Lacs	<input type="checkbox"/> 3 Lacs	<input type="checkbox"/> 4 Lacs	<input type="checkbox"/> 5 Lacs		
• Floater Sum Insured:		<input type="checkbox"/> 3 Lacs	<input type="checkbox"/> 4 Lacs	<input type="checkbox"/> 5 Lacs	<input type="checkbox"/> 10 Lacs	<input type="checkbox"/> 15 Lacs		

Please tick the relevant boxes.

4. Details of Persons Proposed to be Insured

Proposed Insured

Name

Gender Male Female Height (cm) Weight (kg) Date of Birth

Relationship with Proposer Self Spouse Son Daughter Daughter-in-law Father Mother
 Father-in-law Mother-in-law Grandfather Grandmother Grandson Granddaughter Others_____

Nationality

Educational Qualification Non-matric Matric Graduate Post-graduate Professional Course

Occupation Salaried Self employed Student House wife Others

If salaried, specify designation

If self employed, specify business/occupation

Proposed Insured

Name

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Relationship with Proposer Self Spouse Son Daughter Daughter-in-law Father Mother
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Occupation Salaried Self employed Student House wife Others

If salaried, specify designation

If self employed, specify business/occupation

Proposed Insured

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 Father-in-law Mother-in-law Grandfather Grandmother Grandson Granddaughter Others_____

Nationality

Educational Qualification Non-matric Matric Graduate Post-graduate Professional Course

Occupation Salaried Self employed Student House wife Others

If salaried, specify designation

If self employed, specify business/occupation

Note: Premium is for individual age bands and 3 geographical zones.
 If you need more space please use extra sheets.

5. Nomination

In the event of the death of the proposer any payment due under the policy shall become payable to the nominee proposed in this form and the receipt of the proceeds by such nominee would be sufficient discharge to the Company. Nominee for all other persons proposed to be insured shall be the proposer himself/herself. The following section is to be filled by the proposer:

Nominee Name	Relationship	Address of Nominee

6. Medical History

In order for us to service you fully, please answer the questions below accurately to the best of your knowledge.
 Please ensure that you are fully informed about the standard waiting periods and permanent exclusions that apply to the Max Bupa Health Insurance Policies.

Questions	Proposed Insured		Proposed Insured 1		Proposed Insured 2		Proposed Insured 3		Proposed Insured 4		Proposed Insured 5		Proposed Insured 6		Proposed Insured 7		Proposed Insured 8		Proposed Insured 9		Proposed Insured 10		Proposed Insured 11		Proposed Insured 12	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1) Within the last 2 years, have you consulted a doctor or a healthcare professional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Within the last 7 years, have you been to a hospital for an operation and/or an investigation (e.g. scan, x-ray, biopsy or blood tests)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you take tablets, medicines or drugs on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Within the last 3 months, have you experienced any health problems or medical conditions which you have not seen a doctor for?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: We may have additional questions for you or may ask you to undergo medical tests to complete your full medical assessment.

7. Additional Information

If you have answered yes in response to any of the questions in section 6, please give full details here. If you need more space please use extra sheets. If you are unsure whether any details are relevant, please include them.

Name of Proposed Insured	The relevant question number from section 6	Please specify as accurately as possible the symptoms or the medical condition. Where applicable, please state the area of the body affected (e.g. right leg, left eye).	When did the symptoms start and/or when was the treatment completed?	What treatment did you receive and when (please include dates of treatment and any medication prescribed)?	What was the outcome of the treatment (e.g. ongoing, complete recovery, recurrent or likely to recur)?

The following are the permanent exclusions under the Policy. For further details on the exclusions, please refer to the terms and conditions of the Policy.

Addictive conditions and disorders; Ageing and puberty; Artificial life maintenance; Circumcision; Conflict and disaster; Congenital conditions; Convalescence and Rehabilitation; Cosmetic surgery; Dental/oral treatment; Drugs and dressings for Out-patient or take-home use; Experimental treatment; Eyesight; Health hydros, nature cure, wellness clinics etc; Hereditary conditions; HIV and AIDS; Items of personal comfort and convenience; Non-allopathic treatment; Obesity; Out-patient Treatment; Psychiatric and Psychosomatic Conditions ; Reproductive medicine - Birth control & Assisted reproduction; Self-inflicted injuries; Sexual problems and gender issues; Sexually transmitted diseases; Sleep disorders; Speech disorders; Treatment for developmental problems; Treatment received outside India; Unlawful Activity; Unrecognised physician or Hospital, Genetic disorders; any other such permanent exclusions as may be specified in the Schedule

For all insured persons who are above 60 years of age as on the date of commencement of the Policy, the conditions listed below will be subject to a waiting period of 24 months and will be covered in the third Policy Year as long as the Insured Person has been insured continuously under the Policy without any break:

* Stones in the urinary system (example kidney, bladder) Stones in biliary system (example gal stones)* Cataract * Benign prostatic hypertrophy * Mennorrhagia, fibromyoma, uterine prolapse including any condition requiring hysterectomy * Piles (Haemorrhoids) * Hernia (inguinal/umbilical and gastric) * Degenerative disorders of knee/hip * Chronic renal failure or end stage renal failure * Retinopathy * Diabetes and related treatments

If any Insured Person is 65 years of age or over on the date of commencement of the Policy, then Max Bupa Health Insurance Company Limited will only pay 80% of the amount assessed for payment or reimbursement in respect of any claim made by that Insured Person and the balance will be borne by the Insured Person.

There could be certain declined risks as per the underwriting norms of the Company.

Based on our assessment of your health, some conditions may have additional waiting periods or exclusions applicable to any/all of the Proposed Insured.

Coverage Selection: Section II

1. Cost Sharing option(Available only for Silver SI options of Individual and Family Floater Plans):

By choosing one of the cost sharing options below you can get the corresponding discount in your premium calculations for this policy,

- a. 1 Lac annual aggregate deductible.
- b. 2 Lacs annual aggregate deductible.
- c. 3 Lacs annual aggregate deductible.

Deductible option	Premium Discount percentage	You can choose only one option marking "Yes"
1 Lac annual aggregate deductible.	25%	
2 Lacs annual aggregate deductible.	33%	
3 Lacs annual aggregate deductible.	45%	

General Selection: Section III

1. Family Physician's Details

Family Physician's Name

Address

City District

State Pin code

2. Checklist of Documents

a. **ID Proof** Passport PAN Card Voter ID Driving License Letter from Recognised Public Authority Others

b. **Age Proof** School/College Leaving Certificate Passport PAN Card Voter ID

Driving License Letter from Recognised Public Authority Others

3. Existing Insurance Details

Is the proposer or any of the persons proposed to be insured, already insured under or proposed for a health insurance policy for in-patient hospitalisation with Max Bupa Health Insurance Company Limited or any other insurance company?

If yes, please indicate below the Policy/Application number(s) (Please mention the application number in case of a pending proposal)

Since when have you been continuously insured (please provide the insurance history of atleast last 3 years for each proposed insured person if they have been continuously insured)

Name	Policy No.	Application No.	Insured from (date)	To (date)	Sum Insured	Claim details (if any)

In addition to the information given above, please also submit to Us (as an annexure to this proposal form) portability form and all other documents as mentioned in the portability form in order to avail of the portability benefit from your existing insurance policy

4. Renewal Payment Sign-up

Payment of renewal premium of your health insurance policy can be made every year through continuing your existing ECS instructions with Us. 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 Max Bupa.

Would you like to opt for the ECS renewal option at this stage?

Yes No

If you have chosen 'Yes' above please fill up the ECS Mandate form attached along with this form.

5. Caution

You are obliged to make a full and frank disclosure of all facts material to the assumption of risk in relation to you and every person proposed to be insured that would influence our decision to issue a policy, or the terms on which it is issued. You must not misrepresent any information to us. The obligation continues until the Policy is issued, and does not end with the submission of this proposal form. If, therefore, there is any change in the information given herein or new information comes to light before the Policy is issued, then you must inform us of the same in writing without delay. If there is insufficient space to provide additional information, whether as requested or otherwise, then please attach an extra sheet duly signed. If the disclosure obligations are breached then this may render any policy issued void.

6. Authorisation (Please read carefully and put a check mark against each before signing)

- I consent to and authorise Max Bupa Health Insurance Company Limited and/or any of its authorised representatives to seek medical information from any hospital/medical practitioner that I or any person proposed to be insured has attended or may attend in the future concerning any disease or illness or injury.
- I further consent to and authorise Max Bupa Health Insurance Company Limited to use and disclose any personal information collected or available with Max Bupa Health Insurance Company Limited (whether contained in this proposal form or otherwise obtained) to its underwriting personnel, claims investigation companies/agencies/service provider and insurance/reinsurance companies as is necessary and required for the purpose of processing this proposal form and providing subsequent services in relation to the policy and processing of claims under the policy.
- I also consent to provide Max Bupa Health Insurance Company Limited, and /or any of its authorized representatives any information and/or document with regard to the source of my income and age of the Proposed Insured, as may be sought by Max Bupa Health Insurance Company Limited.

Authorization for electronic policy fulfillment and service communications

* I hereby consent that the policy documents may be sent to me by email at _____ (Please provide us your e-mail id)

* I hereby consent to and authorize Max Bupa Health Insurance Company Limited(" Company") to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of the Company from time to time.

Dated

Signature of the Proposer _____

Place _____

Name of Proposer _____

7. Declaration

I hereby declare on my behalf and on behalf of each of the persons proposed to be insured that the above information and the statements provided in this proposal form are true, complete and correct in all respects and that there is no information which is relevant to this application for insurance that has not been disclosed to Max Bupa Health Insurance Company Limited. I further declare that I am related to each of the Proposed Insured in the manner as stated by me herein and I have insurable interest in each of them. I also hereby declare that the money used by me to pay premium under this proposal has not been derived from any criminal or illegal activity or any unaccounted source. I agree that this proposal and any other information provided and the declaration shall be the basis of the contract between me and all persons to be insured and Max Bupa Health Insurance Company Limited.

Dated:

Signature of the Proposer _____

Place _____

Name of Proposer _____

8. 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 Max Bupa Health Insurance Company Limited 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's Name:

Address:

City Pin Code

Signature of declarant: _____ Signature of applicant in vernacular: _____

Acknowledgment

Proposal Form No.

Date

We acknowledge with thanks the receipt of your proposal 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, if any, received from you without interest.

Signature of the receiver and office seal

