

Heartbeat Proposal Form

URN: 010

1. Proposer Details:

Title	Name	
DOB	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Current address		
Landmark		
City		Pincode
District	State	
Landline number	Mobile number	
Email ID	Alternate number	
Aadhaar Number	(Optional)	PAN Number
<small>(Mandatory for premium above Rupees 50,000 in cash and Rupees 1 lac through other modes)</small>		
Nationality	Annual income (Rs)	
Employment	<input type="checkbox"/> Salaried <input type="checkbox"/> Self-employed <input type="checkbox"/> Student <input type="checkbox"/> Housewife <input type="checkbox"/> Other, please specify	
Premium paid by	Relationship with Proposer	
Are you or any of the proposed applicants a PEP#? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

Bank details:

Bank name		
Account number	IFSC Code	
Account type: <input type="checkbox"/> Savings <input type="checkbox"/> Current	Branch	City

Details of Electronic Insurance Account (eIA)

Do you wish to have this Policy credited to an eIA? (Please select any one)

No, I do not have an eIA 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. Details Of Applicants For Insurance:

Applicant 1	Name		
	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Height <input type="text"/> (ft) <input type="text"/> (inch) Weight <input type="text"/> (kg)
	Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Please tick if not Indian <input type="checkbox"/>
	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		

Applicant 2

Name

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

Date of Birth 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

Applicant 3

Name

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

Date of Birth 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

Applicant 4

Name

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

Date of Birth 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

Applicant 5

Name

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

Date of Birth 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

Applicant 6

Name

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

Date of Birth 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

3. 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:

Policy type: Individual Family Floater Family First

Plan type: Silver Gold Platinum

(Note – Silver plan is available only for 'Family First' policy type)

Number of lives to be covered: Adults Children

Coverage for Individual or Family Floater policy type: Base Sum Insured

Coverage for Family First policy type: Individual Sum Insured **Floater Sum Insured**

Policy coverage for silver and gold plan: Zone 1: All India coverage

Zone 2: All India coverage with co-payment applicable for Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata & Gujarat State

Note –

a) If you select Zone 2, then 20% co-payment will apply for treatment in Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata & Gujarat State.

b) Premium for platinum plan is based on the address provided by you. Zone based co-payment is not applicable for platinum plan.

Optional co-payment: 10% 20% No

Policy Term 1 Year 2 Years

Optional coverage:							
		Please tick to opt					
1.	Hospital Cash	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
2.	Please tick 'Yes' if opting for Enhanced Geographical Scope by including USA & Canada for Specified Illness cover, Emergency Medical Evacuation and Emergency Hospitalization (Available under platinum plan only)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
3.	e-consultation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
4.	Premium waiver Note – a) This option is not applicable to individual policy type. b) Proposer has to be an insured person for choosing this optional benefit.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
		Applicant Number					
		1	2	3	4	5	6
5.	Please tick if opting for 'Personal Accident cover' (This option is available only to Applicants of age 18 years or above). • If 'Personal Accident cover' is opted, please tick if the Applicant is 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).	<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"/>
6.	Please tick if opting for 'Critical Illness cover' (This option is available only to Applicants of age 18 years or above) • If 'Critical Illness cover' is opted, please tick if the Applicant have been diagnosed or undergoing treatment for any chronic condition related to heart, brain, lungs, kidneys, liver, pancreas, spleen, intestines, blood vessels, bones/ joints or any other body organ other than minor medical illness.	<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. 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 Name	Date of Birth	Relationship with the Proposer	Address and contact details of Nominee	Appointee Name (if nominee is less than 18 years of age)

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 Max Bupa. Please note any incomplete, incorrect, partially correct information may affect your medical 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											
	1		2		3		4		5		6	
i. Other than common cold, flu, infections, minor injury or other minor ailments; have the Applicant ever been diagnosed with any disease and / or hospitalized for more than 5 days and / or undergone / advised to undergo any surgical procedures and / or taken any medication/ had any symptoms for more than 14 days? Medication is including but not limited to inhalers, injections, oral drugs and external medical applications on body parts.	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ii. Have the Applicant ever had adverse findings to any diagnostic tests or investigations related to 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. Does the Applicant have diabetes or high blood pressure?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
iv. Have the Applicant 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
v. Have the Applicant ever been diagnosed or treated for any mental/ psychiatric disorders?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
vi. Is the Applicant currently pregnant and/ or have had any complications in the current or earlier pregnancies or undergone/undergoing any form of fertility treatment? (applicable to females between the age of 18 to 50 years)	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)	i. Chewable tobacco/Gutkha/ Pan Masala. If yes, please specify number of pouches per day		ii. Alcohol. If yes, please specify number ml per week			iii. Cigarettes/Bidi/Cigar. If yes, please specify consumption per day	
	1-10	> 10	<= 450	> 450	Daily Drinker	1-10	> 10
Applicant 1							
Applicant 2							
Applicant 3							
Applicant 4							
Applicant 5							
Applicant 6							

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 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											
	1		2		3		4		5		6	
	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.

Date 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	<input type="text"/>		
Mobile number of the certifying Person	<input type="text"/>	Signature of the certifying Person	<input type="text"/>
Name of the Witness	<input type="text"/>		
Mobile number of the Witness	<input type="text"/>	Signature of the Witness	<input type="text"/>
		Signature of the Proposer	<input type="text"/>

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	<input type="checkbox"/> Cheque	<input type="checkbox"/> Demand Draft
	<input type="checkbox"/> Credit card	<input type="checkbox"/> Cash
Premium amount	<input type="text"/>	
Online payment transaction ID:	<input type="text"/>	
Date	<input type="text"/>	
Bank name/branch	<input type="text"/>	
Max Bupa branch location	<input type="text"/>	
Code No.	<input type="text"/>	
Business sourced by:	Advisor/DST/Corporate Agency/Other Channels	
Intermediary Name	<input type="text"/>	
Intermediary Code	<input type="text"/>	
Proposal received on:	<input type="text"/>	
Customer ID:	<input type="text"/>	

12. Additional Details For Bancassurance Channel Only (For Office Use Only)

Branch Code	<input type="text"/>	SP Code	<input type="text"/>
RM/LG code	<input type="text"/>		
Customer account number	<input type="text"/>		

13. Insurance Intermediary 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

Signature of the Insurance Intermediary

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.

Disclaimer: Max Bupa Health Insurance Company Limited Corporate Office: B-1/1-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi-110044. Registered Office: Max House, 1, Dr. Jha Marg, Okhla, New Delhi - 110020 Website: www.maxbupa.com, Fax: 011-30902010, Customer Helpline No.: 1860 500 8888. CIN: U66000DL2008PLC182918, IRDAI Registration No. 145. Product Name : Heartbeat, Product UIN No.: MAXHLIP20065V051920 'Max', Max logo, 'Bupa' and Heartbeat logo are registered trademarks of their respective owners and are being used by Max Bupa Health Insurance Company Limited under license. Insurance is the subject matter of solicitation. Please read sales brochure carefully before concluding a sale.

Key Feature Document (KFD)- Heartbeat

Max 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.

'Heartbeat' provides you with a comprehensive range of inpatient benefits. Further, there are some additional benefits under the platinum plan (which are mentioned below) as well as optional benefits for you to buy if you wish to enhance your cover.

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

Base benefits under silver, gold and platinum plans

- Inpatient care at a hospital, including room rent (as per your opted plan) and ICU charges
- Pre and post hospitalization expenses for 60 and 90 days respectively
- Day Care Treatments
- Domiciliary Hospitalization
- Alternative Treatments
- Living Organ Donor Transplant
- Emergency Ambulance
- Maternity Benefit is covered for up to 2 pregnancies or terminations post waiting period of 24 months
- New born baby (including vaccinations of the new born baby)
- Health Check-up, post completion of first policy year
- Refill Benefit up to Base Sum Insured is available only under Individual and Family Floater Plans. Family First plan does not have Refill benefit.
- Pharmacy and Diagnostic booking services
- Loyalty Additions: Post completion of a Policy Year, addition of 10% of the expiring base Sum Insured, subject to a maximum of 100% (50% in case of silver plan) of the base Sum Insured
- Emergency Assistance Services for Medical referral, Emergency medical evacuation, Medical repatriation, Compassionate visit, Care and/or transportation of minor children & Return of mortal remains
- Expenses incurred for Hospitalization (including Day Care Treatment) due to condition caused by or associated with HIV / AIDS are covered under the policy subject to sub-limit as specified in the Policy.
- Expenses incurred for inpatient treatment for mental illness are covered under the policy subject to sub-limit for specific conditions as specified in the Policy.

Additional base benefits under the platinum plan

- Second Medical Opinion on the diagnosis of specified illness or planned surgery
- Child Care Benefits (Vaccinations for children up to 12 years including one consultation for nutrition and growth during the visit for vaccination)
- Specified Illness Cover outside India except USA & Canada
- International coverage outside India except USA & Canada for Emergency Hospitalization and Emergency Medical Evacuation
- OPD Treatment and Diagnostic Services

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 critical illnesses
- Daily hospital cash benefit in case of hospitalization
- Unlimited tele / online medical consultations
- Automatic free of charge extension for 1 year if the Policyholder (who should also be an Insured Person) dies or is diagnosed or undergoes treatment for the first time, with any of the Specified Illness during the Policy (not available for individual cover)
- Enhanced Geographical Scope for extending cover to USA & Canada for Specified Illness cover, Emergency Medical Evacuation – outside the geographical boundaries of India and Emergency Hospitalization – outside the geographical boundaries of India

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

Note that waiting periods are applicable as per the Policy:

- Pre-existing Disease waiting period of 24 months (48 months in case of silver plan) since inception of the Policy and subject to continuous renewal.
- Initial Waiting Period of 30 days unless the treatment needed is the result of an Accident.
- Specific Waiting Period of 24 months 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). This waiting period is applicable only for persons above 45 years of age.
- Mental disorder treatment benefit will have a waiting period of 36 months from inception of the cover with Us, with Mental Illness covered as a benefit, for the respective Insured Person.
- For HIV / AIDS cover, there will be a waiting period of 48 months from inception of the cover with Us, with HIV / AIDS covered as a benefit, for the respective Insured Person.
- For Critical Illness cover, a 90 days initial waiting period along with the Pre-existing Disease waiting period of 4 years and Survival Period exclusion of 30 days will apply for all conditions.

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 4 children) or Family First cover (up to 19 relationships), with any addition or deletion of member(s) in the Policy being done only at the time of renewal.
- Sum Insured (in case of family first): Your plan offers both individual Sum Insured and floater Sum Insured in the same policy. For example, a Family First policy is chosen for 6 members (say self, spouse, parents and two children) with a Sum Insured of 5 Lacs + 30 Lacs. Any member can claim for up to 5 Lacs from his/her Individual Sum Insured. Any claim exceeding 5 Lacs will get covered through floater Sum Insured of 30 Lacs. Hence, an individual member can claim up to 35 Lacs in a single claim, however the floater Sum Insured can be used only up to 30 Lacs for all members together during the policy year. On a cumulative basis in a policy year, total claims can be made is 60Lacs (i.e. 6 members*5 Lacs each + 30 Lacs floater Sum Insured).
- **Lifelong renewability** of your Policy subject to your confirmation and timely payment of the due premium.
- **Your renewal premium will increase as your age increases 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).
- 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.

NOTES:

- Premium: kindly deposit the premium amount through a secure mode of payment in the name of Max Bupa Health Insurance Company Limited.
- In case of any query or claim, please contact our Customer Helpline No: 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.

This Space Has Been Left Blank Intentionally.

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.

___ I want to opt for the ACH/SI renewal option.

Date: _____

Signature of Proposer: _____

Place: _____

Name of Proposer: _____

Max Bupa Health Insurance Company Limited Corporate Office: B-1/I-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi - 110044. Registered office: Max House, 1 Dr. Jha Marg, Okhla, New Delhi-110020. Website: www.maxbupa.com., Fax: 011-30902010; Customer Helpline No.: 1860 500 8888; CIN: U66000DL2008PLC182918. IRDAI Registration No. 145. Product Name: Heartbeat. Product UIN: MAXHLIP20065V051920. 'Max', Max Logo, 'Bupa' and HEARTBEAT logo are trademarks of their respective owners and are being used by Max Bupa Health Insurance Company Limited under license. Insurance is the subject matter of solicitation. Please read sales brochure carefully before concluding a sale.

Acknowledgment By The Company

Application No.

Date

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