

ReAssure Proposal Form



URN: 015

1. Proposer Details:

Title	Name					
DOB	D D M M Y Y Y Y	Gender:	Male	Female	Other	Nationality
Current address						
Landmark						
District			State		City	
Landline number			Mobile number		Pincode	
Email ID			Alternate number			
PAN Number			(Mandatory for premium above Rupees 50,000 in cash and Rupees 1 lac through other modes)			
Annual income (Rs)						
Occupation						
Salaried						
Self-employed						
Student						
Housewife						
Other, please specify						
Premium paid by			Relationship with Proposer			

I wish to receive my policy related information and updates over WhatsApp on my mobile number.

I have read, understood and accepted all Terms and Conditions & hereby authorize Max Bupa Health Insurance or any of its Agents and/or third party(ies) / affiliates to contact me via SMS / Email / Phone / WhatsApp / Facebook or any other modes on my registered phone number over-riding my 'DND' registration to make welcome calls / SMS, service calls / SMS or any other commercial communication.

Are you or any of the proposed applicants a PEP#? Yes 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		City	
Account type						
Savings						
Current						
Branch						

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)

M/s NSDL Database Management Limited M/s Central Insurance Repository Limited
 M/s Karvy Insurance Repository Limited M/s CAMS Repository Services Limited (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).

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 and thereby avail a discount of 2.5% on the premium till the time policy is renewed using the same.

Date D D M M Y Y Y Y Place _____ Signature of the Proposer

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)
	Mobile number				Date of Birth	<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 / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter / Employee										
	If a registered Medical Practitioner*, please provide: i.	Medical Registration Number										
	ii.	Council Name										
iii.	Address of workplace											
Applicant 2	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)
	Mobile number				Date of Birth	<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):	Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter										
	If a registered Medical Practitioner*, please provide: i.	Medical Registration Number										
	ii.	Council Name										
iii.	Address of workplace											
Applicant 3	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)
	Mobile number				Date of Birth	<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):	Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter										
	If a registered Medical Practitioner*, please provide: i.	Medical Registration Number										
	ii.	Council Name										
iii.	Address of workplace											
Applicant 4	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)
	Mobile number				Date of Birth	<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):	Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter										
	If a registered Medical Practitioner*, please provide: i.	Medical Registration Number										
	ii.	Council Name										
iii.	Address of workplace											
Applicant 5	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)
	Mobile number				Date of Birth	<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):	Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter										
	If a registered Medical Practitioner*, please provide: i.	Medical Registration Number										
	ii.	Council Name										
iii.	Address of workplace											
Applicant 6	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)
	Mobile number				Date of Birth	<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):	Spouse / Father / Mother / Father-in-law / Mother-in-law / Son / Daughter										
	If a registered Medical Practitioner*, please provide: i.	Medical Registration Number										
	ii.	Council Name										
iii.	Address of workplace											

* Avail a discount of 5% on the premium. Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

- Notes:** 1. If the relationship of Applicant 1 with Proposer is employee, then the relationship of other Applicants are with Applicant 1.
2. For Live Healthy benefit, eligible Insured Persons will be: a. All members except son / daughter under a Family Floater policy
b. Any member of age atleast 18 years under an Individual policy

3. Coverage selection:

Are you applying for portability:	<input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", please fill the separate portability form also)												
Base coverage:													
Policy type:	<input type="checkbox"/> Individual <input type="checkbox"/> Family Floater												
Base Sum Insured: (Rs.)	<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	4	5	7.5	10	12.5	15	20	25	50	75	1	Cr.
Policy term:	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years												
Optional coverage:													
1. Hospital Cash : Rs 1,000 per day (for Sum Insured up to Rs. 5 Lacs), Rs 2,000 per day (for Sum Insured Rs. 7.5 Lacs to Rs. 15 Lacs) & Rs 4,000 per day (for Sum Insured above Rs. 15 Lacs)	<input type="checkbox"/> Yes <input type="checkbox"/> No												
2. Safeguard	<input type="checkbox"/> Yes <input type="checkbox"/> No												
	Applicant Number												
	1	2	3	4	5	6							
3. Please tick if opting for 'Personal Accident cover' (This option is available only to Applicants of age 18 years or above)	<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, habits and past proposal 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; has 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	Y	N
ii. Has 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	Y	N
iii. Does the Applicant have diabetes or pre-diabetes or has he/she EVER had high blood sugar?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
iv. Does the Applicant have Hypertension or High Blood Pressure?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
v. Has 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	Y	N
vi. Has the Applicant ever been diagnosed or treated for any mental/ psychiatric disorders?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
vii. 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?	Y	N	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. 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

7. 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

8. 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"/>	Signature of the certifying person:	<input type="text"/>	Mobile number of the certifying person:	<input type="text"/>
Name of the Witness	<input type="text"/>	Signature of the Witness	<input type="text"/>	Mobile number of the Witness:	<input type="text"/>
		Signature of the Proposer	<input type="text"/>		

9. 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

10. Premium Details (for office use only)

Premium payment option	<input type="checkbox"/> Cheque	<input type="checkbox"/> Demand Draft	<input type="checkbox"/> Credit card / Debit card	<input type="checkbox"/> Net Banking	<input type="checkbox"/> Cash	<input type="checkbox"/> Others
Premium amount	<input type="text"/>	Online payment transaction ID:	<input type="text"/>	Date	<input type="text"/>	<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				
Code No	<input type="text"/>					
Name	<input type="text"/>					
Proposal received on:	<input type="text"/>	Customer ID:	<input type="text"/>			
Is Proposer or the applicant a staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				

11. 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"/>				

12. Insurance advisor's report (for office use only)

I, in my capacity as an Insurance Advisor / Specified Person of the Corporate Agent / Authorised 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 and further more if there has been a non-disclosure of any material fact, the policy issued to his / her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

Date

Signature of the Insurance Advisor

13. Statutory Warning

Prohibition of Rebates (Under Section 41 of the Insurance Act 1938)

- 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.
- 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, IRDAI Registration No. 145. '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. CIN No. U66000DL2008PLC182918. Registered Office: B-1/I-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi – 110044. Website: www.maxbupa.com, Fax: 011-30902010, Customer Helpline No.: 1860 500 8888. Insurance is the subject matter of solicitation. Please read sales brochure carefully before concluding a sale.

This Space Has Been Left Blank Intentionally.

ReAssure Key Feature Document (KFD)



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.

'ReAssure' provides you with a comprehensive range of inpatient benefits. Further, there are some 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:

- Inpatient care at a hospital, without any room rent restriction and ICU charges
- Pre and post hospitalization expenses for 60 and 180 days respectively
- Day Care Treatments
- Domiciliary Hospitalization
- Alternative Treatments
- Modern treatments with sub-limit of Rs. 1Lac on few robotic surgeries
- Home care treatment
- Living Organ Donor Transplant
- Emergency Ambulance covered up to Rs.2,000 per hospitalization
- Health Check-up, starting from Day 1
- Air Ambulance is covered up to Sum Insured for Cashless claim & up to Rs. 2.5 Lacs for Reimbursement claim
- Booster Benefit: In case of claim free year, increase of 50% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured (In case of a claim, reduction of accumulated Cumulative Bonus by 50% of expiring Base Sum Insured)
- ReAssure benefit provides unlimited reinstatement up to base Sum Insured. (Applicable for both same & different illness)
- Shared accommodation Cash Benefit
- Second Medical Opinion: Once for any condition for which hospitalization is triggered
- Live healthy benefit: Discount on renewal premium basis number of steps taken

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
- Daily hospital cash benefit in case of hospitalization
- Safeguard: Below benefits will be provided under this optional cover:
 - Claim Safeguard: Non-payable items paid up to Sum Insured
 - Booster Benefit Safeguard: No impact on Booster benefit if claim in a policy year is less than Rs. 50,000
 - Sum Insured Safeguard: CPI linked increase in Base Sum Insured

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 36 months 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).

Note that standard 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.

This Space Has Been Left Blank Intentionally.

Other key features of your Policy are as follows:

- In an Individual cover, maximum up to 6 members (maximum of 4 adults and a maximum of 5 children) can be included in a single policy. The 4 adults can be a combination of self, spouse, father, father in law, mother or mother in law. 10% discount on premium if 2 or more members are covered under an individual policy.
- Family floater cover is available for maximum of 2 Adults and 4 children. Relationship allowed for adults in a family floater policy is / are self, spouse, father, father in law, mother or mother in law.
- **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 (30 days if the Policy with Policy Period as 3 years has been sold through distance marketing) 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:

1. Premium: Kindly deposit the premium amount through a secure mode of payment in the name of Max Bupa Health Insurance Company Limited.
2. In case of any query or claim, please contact our Customer Helpline No: 1860-500-8888

Disclaimer: Max Bupa Health Insurance Company Limited, IRDAI Registration No. 145. '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. CIN No. U66000DL2008PLC182918. Registered Office: B-1/I-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi – 110044. Website: www.maxbupa.com, Fax: 011-30902010, Customer Helpline No.: 1860 500 8888. 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