

Max Bupa Health Recharge Proposal Form



URN: 004

1. Proposer details:

Title

Name

Date of Birth Gender: Male Female Other

Current address

Landmark

City District

State Pincode

Landline number Alternate number

Email ID Mobile number

Aadhar Number PAN Number

(Mandatory for premium above Rupees 1 lac)

Nationality Annual income (Rs)

Employment: Salaried Self-employed Student Housewife Other, please specify

Premium paid by Relationship with Proposer

Do You or any of the proposed applicants have an existing policy with Max Bupa? Yes No

If yes, please provide the policy number:

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

Account type: Savings Current Branch City

Details of Electronic Insurance Account (eIA)

Do you wish to have this Policy credited to an e-Insurance account? (Please select any one)

No I do not have an e-insurance account 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).

Version-1B, Sep-19

Product Name: Max Bupa Health Recharge | Product UIN: MAXHLIP18129V011718

2. 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:

Lives to be covered: 1A 1A+1C 1A+2C 2A 2A+1C 2A+2C 2A+3C 2A+4C

Sum Insured: (Rs.) 2 Lacs 3 Lacs 4 Lacs 5 Lacs 7.5Lac 10Lac 15Lac 25Lac

Policy term: 1 Year 2 Years 3 Years

Deductible amount: Please mention the deductible amount chosen (Rs.):

Optional coverage under the product:

a. **Personal Accident Cover:** Yes No

If yes, then please choose the lives to be covered: Primary Insured Person Primary Insured Person along with spouse

Are the lives to be covered under this optional benefit 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)? Yes No

b. **Critical Illness Cover:** Yes No

If yes, then please choose the lives to be covered: Primary Insured Person Primary Insured Person along with spouse

c. **Modification in room rent:** Yes No

(Note: This option is available only for Sum Insured up to Rs. 4 Lacs and deductible more than Rs. 50,000. By selecting this option, entitlement for the maximum room rent eligibility will be Single Private Room)

3. Details of applicants for insurance:

Adult 1	Name	<input type="text"/>									
	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)		
	Waistline	<input type="text"/> (inch)	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"/> <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										

Adult 2	Name	<input type="text"/>									
	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)		
	Waistline	<input type="text"/> (inch)	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"/> <input type="text"/>	Please tick if not Indian <input type="checkbox"/>						
	Relationship: Spouse of Adult 1 <input type="checkbox"/>		Please tick if not Indian <input type="checkbox"/>								

Child 1	Name	<input type="text"/>									
	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)		
	Waistline	<input type="text"/> (inch)	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"/> <input type="text"/>	Please tick if not Indian <input type="checkbox"/>						
	Relationship: Son of Adult 1 <input type="checkbox"/>		Daughter of Adult 1 <input type="checkbox"/>		Please tick if not Indian <input type="checkbox"/>						

Child 2

Name

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

Waistline (inch) Date of Birth

Relationship: Son of Adult 1 Daughter of Adult 1 Please tick if not Indian

Child 3

Name

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

Waistline (inch) Date of Birth

Relationship: Son of Adult 1 Daughter of Adult 1 Please tick if not Indian

Child 4

Name

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

Waistline (inch) Date of Birth

Relationship: Son of Adult 1 Daughter of Adult 1 Please tick if not Indian

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 for all other applicant(s) shall be the proposer himself/herself.

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 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											
	A1		A2		C1		C2		C3		C4	
i. Have you ever been hospitalized for more than 5 days, undergone / advised to undergo any surgical procedures, or taken any medication/ had any symptoms for more than 14 days? Medication is including but not limited to inhalers, injections, oral drugs and topical applications.	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ii. Have you ever had adverse findings to any diagnostic tests or investigations such as Thyroid 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. Do you have diabetes or high blood pressure?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
iv. Do you have any pre-existing diseases / conditions?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

SECTION B: Do you consume any of the following: (Please answer the following questions for each applicant)	Applicant Number											
	A1		A2		C1		C2		C3		C4	
i. Chewable tobacco / Gutkha / Pan Masala. If yes, please specify number of pouches per week												
ii. Alcohol. If yes, please specify number of glasses / ml per week												
iii. Cigarettes / Bidi / Cigar. If yes, please specify consumption per week												

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		Duration of condition	Medication(s)	Dosage	Current status (e.g. Complete / partial recovery or ongoing treatment)	Treating doctor's name & contact details	Documents attached (Yes / No)
	Details	Onset date						

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											
	A1		A2		C1		C2		C3		C4	
	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 Witness: _____

Signature of the Witness

Signature of the Proposer

10. Proposer declaration

(Certification where for any reason, the proposal and other connected papers are not filled in by the prospect).
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 Cheque Demand Draft Credit card Premium amount

Online payment transaction ID: Date

Bank name/ branch

Max Bupa branch location: Code No.

Code No. for business sourced by: Advisor/DST/Corporate agency/other channels

Name

Proposal received on: Customer ID:

Is Proposer or the applicant a staff? Yes No

12. 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 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'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.

Signature of the receiver and office seal

13. Additional details for Bancassurance channel only (for office use only)

Branch Code SP Code
RM/LG code
Customer account number

14. Insurance advisor's 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 conditions for renewability, exclusions 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 material 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 Advisor

15. 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.

Key Feature Document (KFD) – Max Bupa Health Recharge



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.

Max Bupa Health Recharge provides you with a range of benefits at a competitive price, ranging from hospitalisation to multiple optional benefits like personal accident cover and critical illness cover, to better meet your needs.

You have to mandatorily choose an annual aggregate claim deductible amount in this Policy. Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the Deductible has been exhausted.

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

- Inpatient care at a hospital, including room rent and ICU charges
- Pre and post hospitalization expenses for 60 and 90 days respectively
- Alternative Treatment
- Day Care Treatment
- Living organ transplant
- Domiciliary hospitalization
- Emergency ground ambulance
- Unlimited tele / online consultations
- Pharmacy and Diagnostic booking services
- Loyalty Additions: For each Policy Year, We offer an additional 5% of expiring Base sum insured up to at any time a maximum of 50% of base Sum Insured of that Policy Year.
- There will be no increase in sub-limits of room rent & emergency ambulance cover.

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 illnesses*.
- Room rent can be modified to single private room; covered up to Sum Insured (available only for deductible more than INR 50,000 and Sum Insured up to INR 4 Lacs)

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 continuous renewal. For Critical Illness cover, pre-existing disease waiting period would be 48 months.
- Initial Waiting Period of 30 days unless the treatment needed is the result of an Accident. For Critical Illness cover, initial waiting period would be 90 days.
- Specific Waiting Period of 24 months, since the inception of the First Policy with us, 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).
- Please note that Waiting Periods shall not apply to e-Consultation, Personal Accident Cover and Critical Illness Cover, unless mentioned otherwise.

Note that standards exclusions are applicable as set out in the Policy contract. In addition, based on the underwriting results, some specific exclusions might also apply to your Policy.

Other key features of your Policy are as follows:

- Individual or family floater cover (up to 2 adults and 4 children), with any addition or deletion of member(s) in the Policy being done only at the time of renewal.
- **Lifelong renewability** of your Policy subject to your confirmation and timely payment of the due premium.
- **Your renewal premium will increase based on your age band 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).

NOTES:

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.

PREMIUM: KINDLY DEPOSIT THE PREMIUM AMOUNT THROUGH A SECURE MODE OF PAYMENT IN THE NAME OF MAX BUPA HEALTH INSURANCE COMPANY LIMITED.

____ 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.

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 www.maxbupa.com., Fax: 011-30902010; Customer Helpline No.: 1860-500-8888; CIN: U66000DL2008PLC182918. IRDAI Registration No. 145. Product Name: Max Bupa Health Recharge, Product UIN No: MAXHLIP18129V011718. 'Max', 'Max Logo', 'Bupa' and 'HEARTBEAT' logo are owned by Max and Bupa and used under license by us. Insurance is the subject matter of solicitation. Please read sales brochure carefully before concluding a sale.* Subject to maximum of 10 lacs.

Product Name: Max Bupa Health Recharge | Product UIN: MAXHLIP18129V011718