Swasth Parivar Health Insurance Product Proposal Form

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._____

Email ID_____

PAN no._____ (Optional)

Marital Status Single Married/Divorced Widow(er) Separated

Nationality_____

Education Qualification Lesser than matriculation Matriculation Graduate Professional Course

Occupation Salaried Self employed Student House wife 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

2. Plan details

Policy type---------- Individual --------Family Floater --------

If family floater, number of persons to be covered ----2Adults+2Children ----2Adults+1Child------2Adults
----1Adults+1Child -----1 Adult+2Children
---- 1Adult+3Children ---- 1Adult+4Children
---- 2Adults+3Children ---- 2Adults+4Children

3. Sum Insured

Individual/family floater:

Rs 50,000 Rs 100,000

4. Details of person proposed to be insured
Name_____

Gender M F Height (cm) Weight (kgs) Date of birth DD MM YYYY

Self Spouse Son Daughter

Education Qualification Non-matric Matric Graduate Professional

Occupation Salaried Self employed Student House wife Course Others

If salaried, specify designation_____

If self employed, specify business/occupation_____

Details of the proposed insured person 2

Details of person proposed to be insured
Name_____

Gender M F Height (cm) Weight (kgs) Date of birth DD MM YYYY

Self Spouse Son Daughter

Education Qualification Non-matric Matric Graduate Professional

Occupation Salaried Self employed Student House wife Course Others

If salaried, specify designation_____

If self employed, specify business/occupation_____

Details of the proposed insured person 3

Details of person proposed to be insured
Name_____

Gender M F Height (cm) Weight (kgs) Date of birth DD MM YYYY

Self Spouse Son Daughter

Education Qualification Non-matric Matric Graduate Professional

Occupation Salaried Self employed Student House wife Course Others

If salaried, specify designation_____

If self employed, specify business/occupation_____

Details of the proposed insured person 4

Details of person proposed to be insured
Name_____

Gender M F Height (cm) Weight (kgs) Date of birth DD MM YYYY

Self Spouse Son Daughter

Education Qualification Non-matric Matric Graduate Professional

Course

Occupation Salaried Self employed Student House wife Others

If salaried, specify designation_____

If self employed, specify business/occupation_____

Details of the proposed insured person 5

Details of person proposed to be insured
Name_____

Gender M F Height (cm) Weight (kgs) Date of birth DD MM YYYY

Self Spouse Son Daughter

Education Qualification Non-matric Matric Graduate Professional

Occupation Salaried Self employed Student House wife Course Others

If salaried, specify designation_____

If self employed, specify business/occupation_____

Details of the proposed insured person 6

Details of person proposed to be insured
Name_____

Gender M F Height (cm) Weight (kgs) Date of birth DD MM YYYY

Self Spouse Son Daughter

Education Qualification Non-matric Matric Graduate Professional

Occupation Salaried Self employed Student House wife Course 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 the form subject to any change in nomination per the terms of the policy, 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. Following section to be filled by the proposer

Nominee / Guardian (in case of minor)	Relationship with the proposer	Address of Nominee/Guardian

6. Permanent Exclusions and standard waiting periods

Please ensure that you are fully informed about the standard waiting periods and permanent exclusions those apply to the Max Bupa Health Insurance policies.

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; Domiciliary Hospitalisation; Drugs and dressings for OPD Treatment or take-home use; Eyesight; Unproven/Experimental treatment; Health hydros, nature cure, wellness clinics etc.; HIV and AIDS; Hereditary conditions; Items of personal comfort and convenience; Alternative Treatment; Neurological and Psychiatric Conditions; Obesity; Organ Donor; OPD Treatment; Reproductive medicine - Birth control and Assisted reproduction; Self-inflicted injuries; Sexual problems and gender issues; Sexually transmitted diseases; Sleep disorders; Speech disorders; Pregnancy or childbirth, Treatment for developmental problems; Treatment received outside India; Unrecognised physician or Hospital; Unlawful Activity; specific list of costs and expenses that are excluded as per Annexure II of the Terms and Conditions

For all insured persons, 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, Migraine / Vascular headaches, Stones in the urinary system or hepatobiliary system, Surgery on tonsils / adenoids, Any type of cysts, nodules, polyps, Any type of breast lumps, Prostatectomy for Benign Prostate Hypertrophy, Hysterectomy for benign conditions of uterus or other parts of the female reproductive system, Myomectomy for Fibroid Uterus, Heart diseases, Any type of cancer, Gastric and duodenal Ulcers, Thyroidectomy for benign conditions of the thyroid, Varicocele, Spermatocele, Rectal Prolapse, Dilatation and Curettage (D&C), Vitrectomy & retinal detachment surgery for retinopathy, Diabetes and it's direct complications, Fistula in Ano, Fissure in Ano, Hernia, Hydrocele, Haemorrhoids, Sinusitis, Joint replacement procedures, Chronic Renal Failure (CRF) or End stage renal failure, Cataract, Mastoidectomy (operation to remove piece of bone behind the ear), Tympanoplasty (surgery to repair tympanic membrane i.e. eardrum), Surgery of genito urinary tract Gout, Rheumatism, osteoarthritis, spondylosis or spondylitis, degenerative Intervertebral Disc Prolapse and all other degenerative joint disorders, Hypertension, Varicose veins and Varicose ulcers

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

Based on the assessment of your health some conditions may have personal waiting periods or exclusions applicable to any / all of the proposed insured

Please Note:

In all hospitalizations which have not been pre-authorized, we must be notified in writing within 48 hours of admission to the hospital or before discharge from the hospital, whichever is earlier. The notification should be ideally provided by the policyholder/insured person. In the event policyholder and insured person is unwell, then the notification should be provided by any immediate adult member of the family.

Please fill in the following

Family Physicians name_____

Address_____

_____

City_____District_____

State_____Pin code_____

7. Checklist of documents

a. Age Proof School/college leaving certificate Passport Pan Card Others

Voter ID Driving License Letters from Recognised Public Authority

8. 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 inpatient hospitalization with Max Bupa Health Insurance Company Limited or any other insurance company.

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

Since when have you been continuously insured DD MM YYYY

Name	Policy No	Application NO	Insured From(Date)	To(Date)	Sum Insured	Claims details if any

9. Automatic Renewal Sign-up

Your health insurance policy can be automatically renewed every year. Would you like to opt for this facility? Yes No

Signature of the receiver and office seal

10. 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 policy or the terms on which it is issued and 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 may render any policy issued void.

11. Authorisation

__ 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.

__I/We further declare that I/We 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/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

__I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Government and/or Regulatory authority.

Authorization for Company’s authorized representatives

__I consent to and authorize any of Company’s authorized representatives not being direct employees of the Company to seek medical information required for the purpose of policy issuance or claim settlement under this policy from any hospital/medical practitioner that I or any person proposed to be insured/insured has attended or may attend in future concerning any disease or illness or injury.Dated DD MM YYYY Signature of the Proposer_____

Place_____ Name of Proposer_____

12. Declaration

I/We 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/We am/are authorized to propose on behalf of these other persons.

Declaration for Loadings:

I/We undertake that the loadings applicable have been informed and understood by me.

Dated DD MM YYYY Signature of the Proposer_____

Place_____ Name of Proposer_____

13. 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 and the replies have been read out to fully understood and confirmed by the proposer.

Declarants Name_____

Address_____

City_____Pin Code_____

Signature of declarant_____ Signature of applicant in vernacular_____

For Office Use Only

Premium Payment Details Cash Cheque /DD No. Credit Card

Amount Date DD MM YYYY

Bank Name/ Branch

Max Bupa Branch Location Code No

Business Sourced By: Advisor/DST/Corporate Agency/ Other Channels Code No

Name Code No

Proposal Received On:

Processed By Date DD MM YYYY Approved By Date DD MM YYYY

Customer ID

Insurance advisor's report

1. Name of the Proposer

2. Are you related to the Proposer? Yes No

3. If yes, nature of relationship?

4. Is this a proposal form for yourself? Yes No

5. Since when do you know the Proposer? Years Months

6. Are you satisfied with the identity of the proposer? Yes No

7. Does the proposer have any physical deformity/defect or mental retardation? Yes No

8. Have you explained the exclusions of the policy and has the Proposer personally completed the health declaration? Yes No

9. What is the Proposer's state of health at the time of making of this proposal form?

10. Do you recommend acceptance of this proposal form considering all the factors including moral hazard? Yes No

Date DD MM YYYY Signature of the insurance advisor

STATUTORY WARNING AS PER SECTION 41 OF THE INSURANCE ACT 1938

PROHIBITION OF REBATES

Payment of rebates is expressly prohibited 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 or 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 continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the Insurer.

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

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Acknowledgment

Proposal form No. Date DD MM YYYY

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 out 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. I we do not accept the proposal, we will inform you and refund the payment, if any, received from you without interest.

Max Bupa Health Insurance Company Limited
Corporate Office: D-1, 2nd Floor, Salcon Ras Vilas, District Centre, Saket, New Delhi 110017
Registered Office: Max House, 1 Dr. Jha Marg, Okhla, New Delhi 110020
www.maxbupa.com