# MAX BUPA HEALTH INSURANCE COMPANY LIMITED.

## PROPOSAL FORM FOR EMPLOYEE FIRST HEALTH INSURANCE PLAN

Marketing Officer:
Branch Address:

Phone #:

Proposal Form No: | | | | | | | | |

Group I.D.No; | | | | | |

Client I.D.No: | | | | | |

GUIDELINES FOR COMPLETION OF THE FORM

1. Please answer all the questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.

2. Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form. This 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.

3. The Policy shall become voidable at the option of Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or any one acting on his behalf.

4. Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.

NOTE
The liability of the Company does not commence until this proposal has been accepted by the Company and premium received.

SCOPE OF COVER
This Policy covers reimbursement of hospitalisation expenses incurred for diseases contracted or injuries sustained in India.
Medical expenses upto 30 days for Pre – hospitalisation and upto 60 days for post – hospitalisation are also admissible.

SIGNIFICANT EXCLUSIONS
The following is an indicative list of exclusions from the cover under the Policy. For a detailed set of exclusions, kindly consult the policy document.

Pre Existing Conditions, Diseases contracted during first 30 days, Cost of Spectacles / Contact Lenses, Dental/Oral Treatment, HIV and AIDS, Pregnancy and certain specified diseases during first year of the Policy.

PERMANENT EXCLUSIONS
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, Eyesight, Experimental treatment, Health hydros, nature cure, wellness clinics etc., HIV and AIDS, Hereditary conditions, Items of personal comfort and convenience, Non-allopathic treatment, Neurological and Psychiatric Conditions, Obesity, Out-patient Treatment, 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, Unrecognized physician or facility & Unlawful activity

EXTENSIONS
In addition, certain optional extensions are available, the details of which, are provided in the relevant section of this proposal form.

NOTE
The foregoing is only an indication of the cover offered. For details, please refer to the Policy.

DETAILS**:** Put a **(✓)** mark wherever applicable

## 1. CLIENT INFORMATION

(i) Proposer's name (please leave a space after each part of name)

(ii) Proposer's mailing address (please leave a space after each part of address)

City/Town/Village

State

Pin Code

Phone number

Fax number

E-mail address

(iii) Proposer's trade or business

(iv) Paid-up capital of the firm (in Rs. Million)

## 2. Plan Type

Employee First Plan

Employee First – Classic Plan

## 3. RISK DETAILS

(i) Period of Insurance: (DDMMYYYY)

From: To: Midnight

(ii) Number of persons to be insured. ☐☐☐☐☐☐☐☐☐

(iii) Please provide the list of persons to be insured in the following format

For each employee

| Name of the employee (1) | Date of Birth (2) | Gender (3) | Location (City) (4) | Specify existing diseases, if any (6) | Name of Nominee (7) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

For each dependent covered under the same Sum Insured with an employee

| Name of the dependent (8) | Relation with the employee | Date of Birth | Gender | Location (City) | Specify existing diseases, if any |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Note:
Please provide an additional sheet if space is not sufficient to complete details.
Names of the dependent should be mentioned along with the name of the employee they share the sum insured with, please add additional columns in case there are more dependents

(iv) Do all the members proposed to be insured form part of one Corporate body?

Yes ☐ No ☐

(v) Kindly provide the particulars for the past 3 policy periods or less period for which policy availed, in the following format.

| Policy Period From – To | | | | Name & Address of the Insurer | Policy Number | Number of employees/dependents covered | | | | | | Total Premium (Rs.) | | | | | | | | Total amount of claims (Rs.) | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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## 4. Employee First Plan (LOADINGS/DISCOUNTS)

If you want to avail of extension of the policy, please specify below. Please note that an extension of the policy may be subject to payment of additional premium or a discount in premium depending on the type of extension opted:

(i) Maternity Benefits

No ☐ ☐ Yes, **without** 9 month waiting period

☐ Yes, **with** 9 month waiting period

(ii) Inclusion of Parents of the employee as insureds in the group policy

No ☐ ☐ Yes

(iii) Inclusion of Parent-in-laws of the employees as insured in the group policy

No ☐ ☐ Yes

(iv) Waiver of 30 day no claims waiting period

No ☐ ☐ Yes

(v) Waiver of 2 year waiting period for exclusions for specific medical conditions

No ☐ ☐ Yes

(vi) Waiver of 4 year waiting period for Pre-existing Conditions

No ☐ ☐ Yes

(vii) Inclusions of co-pay for all claims for <60 years age

No ☐ ☐ Yes, 10%

Yes, 20% ☐ ☐ Yes, 30%

(viii) Extension of 30 day no claims waiting period to 90 days

No ☐ ☐ Yes

Any additional information relevant to the policy applied for

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

Note : Please use additional sheets if space is not sufficient to complete details.

## 5. Employee First – Classic Plan (LOADINGS/DISCOUNTS)

If you want to avail of extension of the policy, please specify below. Please note that an extension of the policy may be subject to payment of additional premium or a discount in premium depending on the type of extension opted:

(i) Maternity Benefits

No ☐ ☐ Yes, **without** 9 month waiting period

☐ Yes, **with** 9 month waiting period

If yes, please select the coverage from the below grid:

| Sum Insured | Rs 50,000 | Rs 1 Lac | Rs 1.5 lacs, Rs 2 lacs, 2.5 lacs | Rs 3 lacs, Rs 3.5 lacs, Rs 4 lacs, Rs 4.5 lacs, Rs 5 lacs |
|---|---|---|---|---|
| Maternity Cover | ___ Rs 15,000 | ___ Rs 20,000 | ___ Rs 25,000 | ___ Rs 30,000 |
| | | | | ___ Rs 35,000 |
| | | | | ___ Rs 40,000 |
| | | | ___ Rs 30,000 | ___ Rs 45,000 |
| | | | | ___ Rs 50,000 |

(ii) New Born Baby Cover (available only when maternity is opted for)

No ☐ ☐ Yes

(iii) Vaccinations (available only when maternity is opted for)

No ☐ ☐ Yes

(iv) Domiciliary Treatment

No ☐ ☐ Yes

(v) Hospital Accommodation (Room Rent) sub-limit in the base plan is '1% of sum insured or Rs. 3,000 whichever is lower. Please select the option required:

If required, please select coverage from below mentioned grid:

| | | |
|---|---|---|
| Hospital Accommodation (Room rent) | ___ 2% of sum insured or Rs. 4,000 whichever is lower** | ___ No capping* |

(vi) Hospital Accommodation (ICU) sub-limit in the base plan is '2% of sum insured or Rs. 5,000 whichever is lower. Please select the option required:

If required, please select coverage from below mentioned grid:

| | | |
|---|---|---|
| Hospital Accommodation (ICU) | ___ 4% of sum insured or Rs. 7,000 whichever is lower** | ___ No capping* |

* Both these option can only be exercised simultaneously
** Both these option can only be exercised simultaneously

(vii) Corporate Floater – Option 1

If required, please select coverage from below mentioned grid:

| Lives | Up to 300 lives | Greater than 300 lives |
|---|---|---|
| Sum Insured | ___ Rs 5 lacs | ___ Rs 5 lacs |
| | ___ Rs 10 lacs | ___ Rs 10 lacs |
| | | ___ Rs 15 lacs |

(viii) Corporate Floater – Option 2

If required, please select coverage from below mentioned grid:

| Lives | Up to 300 lives | Greater than 300 lives |
|---|---|---|
| Sum Insured | ___ Rs 5 lacs | ___ Rs 5 lacs |
| | ___ Rs 10 lacs | ___ Rs 10 lacs |
| | | ___ Rs 15 lacs |

(ix) Inclusion of Parents of the employee as insured in the group policy

No ☐ ☐ Yes

(x) Inclusion of Parent-in-laws of the employees as insured in the group policy

No ☐ ☐ Yes

(xi) Waiver of 30 day no claims waiting period (Not available along with option (xvi))

No ☐ ☐ Yes

(xii) Waiver of 24 months waiting period for exclusions for specific medical conditions

No ☐ ☐ Yes

(xiii) Waiver of 48 months waiting period for Pre-existing Conditions

No ☐ ☐ Yes

(xiv) Waiver of 20% co-pay for employees 60 years and above

No ☐ ☐ Yes

(xv) Inclusions of co-pay for all claims (Not available along with option (xiv))

No ☐ ☐ Yes, 10%

Yes, 20% ☐ ☐ Yes, 30%

(xvi) Extension of 30 day no claims waiting period to 90 days (Not available along with option (xi))

No ☐ ☐ Yes

I hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects and that there is no information which is relevant to this application for insurance that has not been disclosed to the Company. 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 the Company.

I also consent to provide the Company and/or any of its authorized representatives any information and/or document with regard to the source of income and age of the persons proposed to be insured, as may be sought by the Company.

Place: ☐☐☐☐☐☐☐☐☐☐ Proposer's Signature_____

Date: ☐☐☐☐☐☐☐☐ Name: _____ Designation _____

(DDMMYYYY)

## Acknowledgement

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 official seal

## STATUTORY WARNING

## PROHIBITION OF REBATES.
(Under Section 41 of 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 punishable with fine, which may extend to ten lac rupees.

**Max Bupa Health Insurance Company Limited**
Corporate Office: B-1/I-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi - 110044;
Fax: +91 11 30902010; Toll free: 1860-3010-3333; www.maxbupa.com
Registered Office: Max House, 1 Dr. Jha Marg, Okhla, New Delhi 110020
www.maxbupa.com