MAX BUPA HEALTH INSURANCE COMPANY LIMITED
PROPOSAL FORM FOR **GROUP HEALTH INSURANCE**

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 or proposer 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 expires, 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 Insured or anyone acting on his behalf.

4. Kindly contact Max Bupa Health Insurance Company Limited's Offices or Authorized representative 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 is realized.

SCOPE OF COVER
This Policy offers Basic Benefits like Group Indemnity Cover, Group Hospital Cash Cover, Group Critical Illness Cover, Group Out-Patient Cover, Group Health Checkup Cover and Group Named Illness Cover.

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

Addictive conditions and disorders, ageing and puberty, artificial life maintenance, circumcision, conflict and disaster, external congenital conditions, cosmetic surgery, experimental treatment, health hydros, hereditary conditions, non allopathic treatment, obesity, self inflicted injuries, sexually transmitted diseases, sleep disorders etc.

ADDITIONAL BENEFITS
In addition, certain additional benefits are also available. 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 Documents.

1. CLIENT INFORMATION

I. Name of proposer (organization/institute/association)

(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

Contact number

Fax number

E-mail address

Website

III. Proposer's trade or business or activity

2. RISK DETAILS

i. Period of insurance: (DDMMYYYY)

From: ☐☐☐☐☐☐☐☐ To: Midnight ☐☐☐☐☐☐☐☐

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

Categories of proposed Insured (*Add more categories if needed) – brief description for e.g. senior management, middle management)*

1. **Cat 1:** ______________________
2. **Cat 2:** ______________________
3. **Cat 3:** ______________________
4. **Cat 4:** ______________________
5. **Cat 5:** ______________________

iii. Please provide the details of benefits opted for all members:

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Number of proposed insured					
Basic Benefits					
Section I					
Group Indemnity Cover - Sum Insured					
Plan – *(Individual/Family Floater)*					
Hospital Accommodation – *Please choose the option and specify % or value as applicable*					
Hospital Accommodation [(1)] (ICU) – *Please specify the option A/option B*					
Pre & Post Hospitalization – *Please specify option A/option B*					
Emergency Ground Ambulance – *Please specify option A/option B. Specify amount if option B is opted.*					
Extended Family Cover					
Extended Family Cover* – Additional SI for Parents (Yes/No). *If 'yes', please specify Sum Insured (SI)*					
Extended Family Cover* – Additional SI for Parents-in-law (Yes/No). *If 'yes', please specify Sum Insured (SI)*					
Section II					
Group Hospital Cash per member (Yes/No) *If Yes, please specify days & Sum Insured (SI)/day*	Days ____ SI/day ____	Days ____ SI/day ___	Days ____ SI/day ___	Days ____ SI/day ___	Days ____ SI/day ___
Section III					
Group Critical illness (Yes/No) If Yes, please specify Sum Insured/member					
Section IV					
Group OPD Treatment Cover (Yes/No) *If Yes, please specify Sum Insured/member and Co-payment (upto 50%)*	SI ____ % ____	SI ____ % ____	SI ____ % ____	SI ____ % ____	SI ____ % ____
Section V					
Group Health Checkup If *Yes, please specify Sum Insured/member and Co-payment (upto 50%)*	SI ____ % ____	SI ____ % ____	SI ____ % ____	SI ____ % ____	SI ____ % ____
Waivers and Discounts (available with Section I only)					

Co-payment for members older than specified age (Yes/No) *If Yes, please specify percentage upto 50% and age*	% - _____ Age - ____	% - _____ Age - ___	% - _____ Age - ___	% - _____ Age - ___	% - _____ Age - ___
Co-payment for Primary Insured [(2)] (Yes/No) *If Yes, please specify percentage upto 50%*					
Co-payment for Spouse (Yes/No) *If Yes, please specify percentage upto 50%*					
Co-payment for Children (Yes/No) *If Yes, please specify percentage upto 50%*					
Co-payment for Parents (Yes/No) *If Yes, please specify percentage upto 50%*					
Co-payment for Parents-in-law (Yes/No) *If Yes, please specify percentage upto 50%*					
Sub-limit for Spouse (Yes/No) *If Yes, please specify percentage upto 100%*					
Sub-limit for Children (Yes/No) *If Yes, please specify percentage upto 100%*					
Coverage for Parents within Primary Insured's Sum Insured (Yes/No) *If Yes, please specify sub-limit percentage upto 100%*					
Coverage for Parents and Parents-in-law within Primary Insured's Sum Insured (Yes/No) *If Yes, please specify sub-limit percentage upto 100%*					
Sub-limit for specified illness or conditions *(Yes/No)* *If Yes, please specify option A/option B/option C*					
Waiver of 30 day initial waiting period *(Yes/No)*					
Waiver of 24 month waiting period for Specific Exclusions *(Yes/No)* *If Yes, please specify option A/option B*					
Waiver of 48 month waiting period for Pre-existing Diseases (not available for Group CI) – *Yes/No* *If Yes, please specify option A/option B/option C/option D*					
Waiver of 9 month waiting period for Maternity *(Yes/No)*					
Restriction of cashless treatment in specified provider network *(Yes/No)*					
Claim Settlement on reimbursement basis only *(applicable for section I & additional benefits under Product Benefit Table) – Yes/No*					
In-patient treatment under Alternative Treatments. *If 'yes', please specify Sum Insured (SI)*					

(1) Option B has to be selected if Option D has been opted for Hospital Accommodation (room rent/day)

(2) If opted will become applicable for Primary Insured and all dependents

* additional cover upto Primary Insured's Sum Insured

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

3. Benefit that can be purchased on standalone basis

(i) Group Named illness Cover

No ☐ Yes ☐

If Yes,

1. *Please specify names of illnesses for which coverage is needed*___________________________
2. *Please select the Sum Insured* ____
3. *Please specify the Initial Waiting Period* ____

Riders Available and opted for:

i. Corporate Floater Sum Insured _____________

(Can be opted up to 10% of Aggregate Sum Insured)

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Maternity Benefits					
Maternity Cover (3) *(with 9 month waiting period).Please specify the Sum Insured*	Norma l____ Caesarean ___	Normal ____ Caesarean___	Normal___ Caesarean _	Normal ___ Caesarean _	Norma l__ Caesarean _
Newborn Baby cover – *Please specify option A/option B/option C*					
Vaccinations for Newborn in first year after birth– *Please specify yes/no*					
Domiciliary Hospitalization					
Domiciliary Hospitalization *(Yes/No)* *– If 'yes', please specify percentage of sum insured*					
Corporate Floater					
Corporate Floater (Option 1) – *if opted please specify option A/option B/option C*					
Corporate Floater (Option 2) – *if opted please specify option A/option B/option C*					

(3) coverage limited upto family floater Sum Insured or mother's individual Sum Insured subject to maximum of Rs 1 lac

4. Please provide details of Insured in the following format *(for named policies only)*

Member's Unique ID	Category	Name of the proposed Insured	Date of birth/Age	Gender	Relationship with Primary Insured	City of residence	Designation Or Occupation	Any existing Illness	Nominee Details	
									Name	Relation with Insured Person

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

5. Any additional information material to assumption of risk:

____
____
____
____

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

6. Previous Policy Details

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 of the Insurer	Policy number	Number of members covered	Total premium (Rs.)	Total amount of claims *(Paid + Outstanding)* (Rs.)

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

Place: ☐☐☐☐☐☐☐☐☐☐ Proposer's Signature___________________________

Date: ☐☐☐☐☐☐☐☐ Name: _______________ Designation __________

(DDMMYYYY)

7. **Authorisation** (Please read carefully and put a check mark against each before signing)

__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.

Place___________________ Proposer's Signature ________________________

Date: ☐☐☐☐☐☐☐☐ Name:_______________Designation __________

8. **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____

Relationship with proposer ____

Address____

City____________________________________Pin code__________________________

Signature of declarant_________________ Signature of applicant in vernacular_______________

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 five hundred rupees.

Max Bupa Health Insurance Company Limited
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