Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerawada, Pune - 411006. Reg No.: 113.
CIN: U66010PN2000PLC015329 / UIN- BAJHLIP2540V012425
Email: bagichelp@bajajallianz.co.in | Website: www.bajajallianz.com

For Office Use Only:

Scrutiny No.	Receipt No.	Policy No.

For Agent Use Only:

Intermediary Name	Intermediary Code

Proposal Form

Proposal form Unique Reference Number – BAGIC/ Health/ Individual/037

HERizon Care

Instructions for filling up the form

1. Please answer all questions in BLOCK letters
2. The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid
3. This Proposal will be the basis of any subsequent policy that we issue to you. It is therefore essential that you provide all the information in this Proposal FULLY AND ACCURATELY and that you provide us with any and all additional information relevant to risk to be insured or our decision as to acceptance of the risk or the terms upon which it should be accepted

1) Full Name : Title ☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Name ☐☐☐☐☐☐☐☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2) Are you an existing Bajaj Allianz General Insurance Company Customer :Yes/No, if Yes please mention the Policy No.: OG_____ and PID No: _____

☐ I hereby confirm that, there is no change in my existing KYC details that are available from my previous/existing policy

3) Gender : ☐ Male ☐ Female ☐ Other

4) Date of Birth D D M M Y Y Y Y

5) Pan No. ☐☐☐☐☐☐☐☐☐☐

6)

6) UID/Aadhaar No. ☐☐☐☐☐☐☐☐☐☐☐☐

7) Bajaj Allianz Employee Code , if Proposer is BAGIC/BALIC Employee ☐☐☐☐☐☐

8) Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

9) No. of children: _____

10) Occupation ☐ Business ☐ Salaried ☐ Professional ☐ Student ☐ House wife ☐ Retired ☐ Other _____

10.a) Are you or any of your family members registered under the Ayushmaan Bharat Yojana? ☐ Yes ☐ No

If Yes please share your Ayushmaan Bharat Health Account Number (ABHA) No._____

☐ ABHA Declaration (Applicable only if you have shared the ABHA number with Us) I/We provide my/ our consent to access my/ our (all insured) medical and personal records/ details, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider/s of Bajaj Allianz and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations

11. a. Permanent /Residential Address

House No.: _____House Name : _____

Landmark/Locality: _____

Road/Area Name: _____

City/District: _____

State: _____

Pin Code: ☐☐☐☐☐☐

Telephone: _____ Mobile:_____

Email: _____

11.b.Communication Address (all communications will be sent to below

House No.: _____ House Name : _____

Landmark/Locality: _____

Road/Area Name: _____

City/District: _____

State: _____

Pin Code: ☐☐☐☐☐☐

Telephone: _____ Mobile: _____

Email: _____

12. Educational Qualification: ☐ Matriculate ☐ Undergraduate ☐ Graduate ☐ Post Graduate ☐ Professionally Qualified

13. Family Monthly Income: ☐ Up to ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1Lakh ☐ Above ₹ 1Lakh

14. In case of any Offer, you would prefer to be contacted by: ☐ Phone ☐ Email

15. Nationality ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

16. Policy Period: ☐ 1 Year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years

17 . Details Of Persons To Be Insured

Member Name	DOB	Age	Gender	Ht. (cms)	Wt. (kgs)	Occupation	Relation	Gross monthly Income
Proposer/Primary Insured 1	*(dd/mm/yy)*					☐ Business ☐ Salaried ☐ Non-earning		
Insured 2	*(dd/mm/yy)*					☐ Business ☐ Salaried ☐ Non-earning		
Insured 3	*(dd/mm/yy)*					☐ Business ☐ Salaried ☐ Non-earning		

Insured 4	*(dd/mm/yy)*					☐ Business ☐ Salaried ☐ Non-earning		
Insured 5	*(dd/mm/yy)*					☐ Business ☐ Salaried ☐ Non-earning		
Insured 6	*(dd/mm/yy)*					☐ Business ☐ Salaried ☐ Non-earning		
Insured 7	*(dd/mm/yy)*					☐ Business ☐ Salaried ☐ Non-earning		

Nominee Details:	**Name**	**DOB (dd/mm/yyyy)**	**Age**	**Relation**
Nominee*				
Appointee (If nominee is minor)				
*If Nominee is "Others" please specify the relationship and reason*____				
**Nominee for Self (Primary Insured/Proposer) has to be one of the mentioned relations - Father/ Mother / Son / Daughter / Spouse/other* **For all family member Primary insured will be the Nominee*				

18. Details Of Covers Opted

Benefits offered	**Primary Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**	**Insured 7**
Vita Shield (Your shield against major Critical illness) : ☐ Opted ☐ Not Opted Age eligibility : Adult 18 – 80 years, Child 90 days to 35 years							
Sum inured(SI) Adult – ₹ 3 Lacs to ₹2 Cr Child – ₹ 3Lacs to 10 Lacs SI should be in multiples of Rs. 1 Lakh *SI for Insured 2-7cannot be higher than primary insured*	☐ 3,00,000 ☐ 5,00,000 ☐ 7,50,000 ☐ 10,00,000 ☐ 15,00,000 ☐ 20,00,000 ☐ 25,00,000 ☐ 50,00,000 ☐ 1,00,00,000 ☐ 2,00,00,000	☐ 3,00,000 ☐ 5,00,000 ☐ 7,50,000 ☐ 10,00,000 ☐ 15,00,000 ☐ 20,00,000 ☐ 25,00,000 ☐ 50,00,000 ☐ 1,00,00,00 ☐ 2,00,00,000	☐ 3,00,000 ☐ 5,00,000 ☐ 7,50,000 ☐ 10,00,000 ☐ 15,00,000 ☐ 20,00,000 ☐ 25,00,000 ☐ 50,00,000 ☐ 1,00,00,00 ☐ 2,00,00,000	☐ 3,00,000 ☐ 5,00,000 ☐ 7,50,000 ☐ 10,00,000 ☐ 15,00,000 ☐ 20,00,000 ☐ 25,00,000 ☐ 50,00,000 ☐ 1,00,00,00 ☐ 2,00,00,000	☐ 3,00,000 ☐ 5,00,000 ☐ 7,50,000 ☐ 10,00,000 ☐ 15,00,000 ☐ 20,00,000 ☐ 25,00,000 ☐ 50,00,000 ☐ 1,00,00,00 ☐ 2,00,00,000	☐ 3,00,000 ☐ 5,00,000 ☐ 7,50,000 ☐ 10,00,000 ☐ 15,00,000 ☐ 20,00,000 ☐ 25,00,000 ☐ 50,00,000 ☐ 1,00,00,00 ☐ 2,00,00,000	☐ 3,00,000 ☐ 5,00,000 ☐ 7,50,000 ☐ 10,00,000 ☐ 15,00,000 ☐ 20,00,000 ☐ 25,00,000 ☐ 50,00,000 ☐ 1,00,00,00 ☐ 2,00,00,000
Waiting period	☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days	☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days	☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days	☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days	☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days	☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days	☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days
Survival period opted	☐ NIL ☐ 7 days ☐ 15 days ☐ 30 days	☐ NIL ☐ 7 days ☐ 15 days ☐ 30 days	☐ NIL ☐ 7 days ☐ 15 days ☐ 30 days	☐ NIL ☐ 7 days ☐ 15 days ☐ 30 days	☐ NIL ☐ 7 days ☐ 15 days ☐ 30 days	☐ NIL ☐ 7 days ☐ 15 days ☐ 30 days	☐ NIL ☐ 7 days ☐ 15 days ☐ 30 days
Extensions to Vita Shield Age eligibility : Adult 18 – 80 years							
Extension 1. Children Education Bonus	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted
Extension 2. Loss of Job	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted
Extension 3. Incidental Expense	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted	☐ Opted ☐ Not Opted
Optional Covers** Age eligibility : Adult 18 – 80 years							
Nurture Nest (Baby bearing Support)	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000
Mother Hood (ART and Maternity Expense support)	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ Not opted ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000
Fetal Flourish (Health support for your Unborn child)	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000 ☐ ₹4,00,00 ☐ ₹5,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000 ☐ ₹4,00,00 ☐ ₹5,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000 ☐ ₹4,00,00 ☐ ₹5,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000 ☐ ₹4,00,000 ☐ ₹5,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000 ☐ ₹4,00,000 ☐ ₹5,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000 ☐ ₹4,00,00 ☐ ₹5,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000 ☐ ₹4,00,000 ☐ ₹5,00,000
Extension 4. Hospital Daily allowance	☐ ₹1000/day ☐ ₹ 1500/day ☐ ₹ 2000/day						

Prophylactic Surgeries	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000	☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000
Legal Expense Support	☐ Opted ☐ Non Opted						
***If opted out at renewal and want to opt back in future, waiting periods will apply afresh*							
Cradle Care : Surrogacy and Oocyte donor cover							
☐ Surrogacy Cover	☐ ₹ 50,000 ☐ ₹ 1,00,000						
☐ Oocyte Donor cover	☐ ₹ 50,000 ☐ ₹ 1,00,000						
Health Prime Rider #							
Co payment ☐ Yes ☐ No	Cover type ☐ Individual ☐ Floater	Plan Option _____					

If Health Prime Rider is opted long term policy can be offered only up to 3 years

19) Health Status

PLEASE ANSWER ALL QUESTIONS

	Primary Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7
1. Are you in good health and entirely free from any mental or physical impairments or deformities?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you lost/gained weight over the last 12 months? Reason for weight change: _____	☐ Yes If yes _____kgs. ☐ No	☐ Yes If yes _____kgs. ☐ No	☐ Yes If yes _____kgs. ☐ No	☐ Yes If yes _____kgs. ☐ No	☐ Yes If yes _____kgs. ☐ No	☐ Yes If yes _____kgs. ☐ No	☐ Yes If yes _____kgs. ☐ No
3. Have you ever been diagnosed with / advised / taken treatment or observation is suggested or undergone any investigation or consulted a doctor or undergone or advised surgery or hospitalized for any one or more from the following? If YES then please mention Details in the additional information section below							
a) Hypertension / High Blood Pressure (BP) / High Cholesterol / Any other Lipid disorders diseases of the arteries and veins)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Any Heart Disease or Disorder, Chest Pain or Discomfort, Irregular Heartbeats, Palpitations or Heart Murmur, rheumatic fever etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia or emphysema)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Diseases of the gastrointestinal system (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B, hepatitis C or other disorders of the liver, disorders of the gall bladder)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Diseases of the nervous system or mental disorders (e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) Current/ past history of Cancer, Tumor, Polyp or Cyst	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) Current/ past history of Diabetes mellitus , Insulin resistance	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) Current/ past history of mental or psychiatric disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) Any other diseases or ailments not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you ever had or been advised to have hospital treatment or surgery?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you ever had or been advised to have a blood test for AIDS or an AIDS-related condition or have you ever been refused as a blood donor?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. In the past 5 years, have you consulted a physician for any reason or have you had any investigation such as blood or urine tests, X-rays, electrocardiograms, ultra sonograms, CT scans or biopsy, other than for routine employment or immigration purposes?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you ever taken narcotics or other habit forming drugs or been treated or advised in connection with alcohol/drug dependence ?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

8. Do you participate or do you intend to participate in any hazardous sports or activities such as motor sports, climbing, parachuting, hang-gliding, or aviation except as a fare-paying passenger?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. Are you pregnant? If yes, please state how many months. Please state if you had any pregnancy related complication during your previous pregnancy/delivery? ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10. Have any of your immediate family members (father, mother, brother or sister) have/ had diabetes, hypertension, cancer, heart attack, or stroke and at what age? If yes, was it before age 60 years or after 60 years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11. Are you HPV vaccinated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

12. Additional details in case of Cradle Care cover : Surrogacy and Oocyte donor cover

a. Name of Person to be insured :

b. Age: c. Date of birth: dd/mm/yyyy d. Aadhaar number: XXXX-XXXX-_____

e. Any previous history of Oocyte Donation :

f. Any previous history of Surrogacy

g. I am in good health and entirely free from any mental or physical impairments or deformities.

Place : Signature/ Thumb Impression

Date : of Surrogate Mother/Oocyte donor

If you answered "yes" to any of the questions numbered 1 to 14 (in Section 19 Health Status), please share details in below table

Name of the person	Details of Previous or Current Medical Condition	Treatment Details	Date First treated	Current Status of Illness/Disease /Injury

16) Payment Details ☐ Cash ☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card

Amount	Transaction No.	Transaction Date	Bank Name	Branch

Electronic-Insurance Account:

Please provide e-IA No. to deposit your insurance policy. :

Do you want to open e-IA account: ☐ Yes/ ☐ No

Bank Details

Bank Account detail *:	**Name as per Bank Account**	**Name of the Bank**	**Bank Account No.**	**IFSC Code**	**Account Type**
Contact detail *:	**Mobile No.**	**Email Address**			

☐ *I/We hereby authorize Bajaj Allianz General Insurance Company Limited ("the Company") to refund any amount related to my policy and/or claim directly credited to my aforesaid Bank Account and also agree to inform if there is any change in the above contact or bank details, for ensuring smooth policy servicing.*

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.

I understand that the information provided by me will form the basis of the Individual Policy/floater Policy, and the proposal is subject to the Board approved underwriting policy of the Company and that the Policy will come into force only after Company's full receipt and realization 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 Insured Person(s) to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the Company. Upon renewal of Policy, I/We agree to abide by the standard Terms and Conditions, unless otherwise mentioned by the Company in renewal Policy Schedule or attachments thereto.

I/ We declare and consent to the company seeking medical information from any doctor or from a hospital/institution who at any time has attended on the Proposer/Insured Person to be insured 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 reinsurer, Governmental and/or Regulatory authority.

Date:

D	D	M	M	Y	Y	Y	Y

Place____________________

Signature/ Thumb Impression of the Proposer

Date:

D	D	M	M	Y	Y	Y	Y

Place:

Signature of Intermediary

Date:

D	D	M	M	Y	Y	Y	Y

Place____________________

Signature/ Thumb Impression
Surrogate mother/Oocyte Donor

**The content of this form and its particulars have been explained by me in vernacular language to the proposer who has understood and confirmed the same.

Signature of Proposer:		Name of Witness:		
Date: ___________	Place: ______________	Signature of Witness:	Signature of Intermediary	Signature of Proposer

*Please read declaration wordings carefully before signing the proposal form.
**This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer or if the Prospect/Propose is not knowing English.

Disability Declaration	
Any Physical deformity or handicap? ☐ Yes ☐ No	
If Yes. Please provide details: ____ (Disability Certificate issued by the Medical Board appointed by the Government for certifying Disability)	
I ____ authorised representative of Mr./Miss/Mrs. ____________________________________hereby giving consent on the behalf of the proposer due to his/her disability, that he/she has understood the content of this form and its particulars and confirmed the same.	
Name of Authorised Representative:	Date:
Signature of Authorised Representative:	Place:

INSURANCE ACT 1938 SECTION 41- Prohibition of Rebates

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 prospectus or tables of the insurer. Any person making default in complyingwiththeprovisionsofthissectionshallbeliableforapenaltywhichmayextendtotenlakhrupees.

GoGreen **To support our Go Green initiative, we will send policy copy link on your registered mobile number / email id. This is a digitally signed valid document. Please tick the box, if you still want to receive physical copy of your insurance policy.** ☐

- -

ACKNOWLEDGMENT:

Received from Ms. / Mrs. /
Mr:____

Sum of Rs.____________________________________through Cash# / Cheque / DD / Credit Card / Debit Card No.________________against your proposal for Health Policy.

Signature of Bajaj Allianz Official/ Intermediary
Bajaj Allianz Official / Intermediary Name: ____

Note: Neither the submission of a completed proposal for insurance or any payment for any policy sought oblige the Company to agree to issue a policy, which decision is and always shall be in the Company's sole and absolute discretion.

PORTABILITY FORM

PARTI

1) Name of the Policyholder/ insured(s)_____

2) Date of Birth / Age_____

3) Address of policyholder/insured_____

4) Details of existing insurer

i. Name of the product_____

ii. Sum Insured_____

iii. Cumulative Bonus_____

iv. Addons/Riders taken_____

v. Policy Number_____

5) Details of the proposed insurance

i. Name of the product proposed/intended to take_____

ii. Sum insured proposed_____

iii. Whether Cumulative Bonus to be converted to an enhanced sum insured_____

6) Reason (s) of portability_____

7) No of family member to be included in the policy to be ported_____

First Name of Insured	Details of previous health insurance policy /Policy number	Health Id card number	Sum Insured	CB	Previous Insurance		First policy inception date
					From dd/mm/yy	To dd/mm/yy	

Enclosure: Photocopy of the existing policy documents Date_/_____/_____

PARTII

1. Whether the PED exclusions/ timebound exclusion have longer exclusion period than existing policy (Please indicate Yes/No) ☐ Yes ☐ No

2. If yes, please give written consent to the declaration below:

I am aware that the waiting period for the following disease (s)/treatment (s) is……..days/years more than the previous policy terms,

I hereby agree to observe the additional waiting period for the following diseases(s)/ treatments(s)

Signature of Policyholder