Caringly yours

BAJAJ | Allianz

DIGITAL CUSTOMER FORM

Bajaj Allianz General Insurance Co. Ltd
G.E. Plaza, Airport Road, Yerawada,Pune - 411006.

For Agent Use Only :					
Loan Account Number	Emp/LG Code	IMD Code	Sub IMD Code	IMD Name	Mobile No.

HEALTH GUARD

Proposer Details

1. Full Name: Title* First Name* Middle Name Surname*

2. Are you an existing Bajaj Allianz Customer: Y es / No If yes, please mention the Policy No: OG

3. Gender:* ☐ Male ☐ Female ☐ Other 4. Date of Birth* dd/mm/yyyy

5. PAN No.

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

8. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed 9. No. of Children _____Sons _____Daughters

10. Occupation ☐ Business ☐ Salaried ☐ Professional ☐ Student ☐ House Wife ☐ Retired ☐ Others

11a) Permanent / Residential Address :*

House No & Name

Landmark/Locality

Road/Area Name City

State Pin Code

Telephone (Res.) Telephone (Office)

Mobile Number E-Mail

11b) Correspondence Address : (All the communications will be sent to the below address) Same as Above ☐

House No & Name

Landmark/Locality

Road/Area Name City

State Pin Code

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

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

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

15. Nationality* 16. Policy Period:* ☐ 1 year ☐ 2 year ☐ 3 year

17. Plan:* ☐ Silver ☐ Gold

18. Sum Insured Options*

a) Health Guard Individual Sum insured: ☐ Please mention the member wise sum insured in the member details table

b) Health Guard Family Floater Sum Insured – please select the sum insured option from below

☐ 1.5 lacs ☐ 2 lacs ☐ 3 lacs ☐ 4 lacs ☐ 5 lacs ☐ 7.5 lacs ☐ 10 lacs ☐ 15 lacs ☐ 20 lacs ☐ 25 lacs ☐ 30 lacs ☐ 35 lacs ☐ 40 lacs ☐ 45 lacs ☐ 50 lacs

19. Premium Payment Zone:* ☐ Zone A ☐ Zone B

There are Two Zones for Premium payment

Zone A: "Following cities has been clubbed in Zone A:-
Delhi / NCR, Mumbai including Navi Mumbai, Thane and Kalyan, Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara and Surat.

Zone B: Rest of India apart from Zone A cities are classified as Zone B.

Note:-
Policyholders paying Zone A premium rates can avail treatment allover India without any co-payment.
But, those, who pay zone B premium rates and avail treatment in Zone A city will have to pay 20% co-payment on admissible claim amount. This Co – payment will not be applicable for Accidental Hospitalization cases."
Policyholder residing in Zone B can choose to pay premium for Zone A and avail treatment all over India without any co-payment.

20. Co pay Discount: ☐ Yes ☐ No (If yes please choose from below options)
☐ 10% ☐ 20%

Note:If opted voluntarily by the Insured then Insured will be eligible of additional 10% or20% discount respectively on the policy premium. In case of a claim has been admitted under In-patient Hospitalisation Treatment then, the insured person shall bear 10% or 20% respectively of the eligible claim amount payable under this cover.

21. DETAILS OF PERSONS TO BE INSURED

Member Details*	Relationship with Proposer	Date of Birth DD/MM/YYYY	Age	Height (cms)	Weight (Kg)	Gender (M/ F)	Sum Insured	Nominee	Nominee Relationship with Insured
		dd/mm/yyyy							
		dd/mm/yyyy							
		dd/mm/yyyy							
		dd/mm/yyyy							
		dd/mm/yyyy							
		dd/mm/yyyy							

22. Has any of the persons to be insured suffer from/or investigated for any of the following?*
Disorder of the heart, or circulatory system, chest pain, high blood pressure, stroke, asthma any respiratory conditions, cancer tumor lump of any kind, diabetes, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychiatric conditions, any disease of brain or nervous system, fits (epilepsy) slipped disc, backache, any congenital/ birth defects/ urinary diseases, AIDS or positive HIV, If yes, indicate in the table given below. ☐ Yes/ ☐ No
If yes please provide details

23. Do you or any of the family members to be covered have/had any health complaints/met with any accident in the past and have been taking treatment/ hospitalization? (Please provide details in the table given below)

Sr. No	Name of the person	Name of the Illness/injury suffered / suffering in the past	Treatment details	Date first treated	Current Status of the Illness/Diseases/Injury
1				dd/mm/yyyy	
2				dd/mm/yyyy	
3				dd/mm/yyyy	
4				dd/mm/yyyy	
5				dd/mm/yyyy	
6				dd/mm/yyyy	
7				dd/mm/yyyy	
8				dd/mm/yyyy	

* These fields are mandatory, please fill all the required details

Save