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 INFINITY

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) Details Of Persons To Be Insured

Member Details	Relationship with Proposer	Date of Birth DD/MM/YYYY	Age	Gender (M/ F)	Per Day Room Rent	Occupation	wt.	ht.	Nominee	Nominee Relationship with Insured	Co-payment Option 15% / 20% / 25%

wt.-Weight, ht.-Height

18) 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

19) 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

20). Payment Details ☐ Cash ☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card

Amount	Transaction No.	Transaction Dt.	Bank/Name	Branch