Bajaj Allianz General Insurance Co. Ltd.

Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113

Caringly yours

BAJAJ | Allianz

DIGITAL CUSTOMER FORM

For Agent Use Only :	
Intermediary Name	Intermediary Code

STAR PACKAGE

Proposer Details

1. Full Name: Title* K | First Name* K A U S T U B H
   Middle Name V A S A N T | Surname* G H O L A P
2. Are you an existing Bajaj Allianz Customer: Y es / No If yes, please mention the Policy No: OG-19-20002-
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

16) Policy Period : ☐ 1 year ☐ 2 year ☐ 3 year

17) Plan Details

Minimum three sections to be opted

a) **HEALTH GUARD SECTION**

i) Plan ☐ Silver ☑ Gold

ii) Policy Type ☐ Individual ☑ Floater

iii) Sum Insured options

Health Guard –Silver ☐ ₹ 1,50,000 ☐ ₹ 2,00,000

Health Guard –Gold ☐ ₹ 3,00,000 ☑ ₹ 4,00,000 ☐ ₹ 5,00,000 ☐ ₹ 7,50,000 ☐ ₹ 10,00,000 ☐ ₹ 15,00,000 ☐ ₹ 20,00,000
☐ ₹ 25,00,000 ☐ ₹ 30,00,000 ☐ ₹ 35,00,000 ☐ ₹ 40,00,000 ☐ ₹ 45,00,000 ☐ ₹ 50,00,000

iv) Voluntary co pay ☐ 10% ☐ 20%

v) Premium Payment Zones ☐ Zone A ☐ Zone B

b) Please encircle the cover to be opted

Section	Products	Plan A	Plan B	Plan C	Plan D
1	Hospital Cash	☐ 500	☐ 1000	☐ 2000	☐ 2500
2	Critical Illness	☐ 100000	☐ 150000	☐ 200000	☐ 300000
3	Personal Accident	☐ 200000	☐ 300000	☐ 400000	☐ 500000
4	Education Grant	☐ 200000	☐ 300000	☐ 400000	☐ 500000
5	Householders contents	☐ 100000	☐ 200000	☐ 300000	☐ 400000
6	Traveling Baggage	☐ 10000	☐ 20000	☐ 30000	☐ 40000
7	Public liability	☐ 200000	☐ 300000	☐ 400000	☐ 500000

c) Total no of sections opted for _____

d) Critical Illness: Please indicate if you want option for family floater ☐ Yes ☐ No

☐ Self + Spouse ☐ Self + Spouse + 1 Child ☐ Self + Spouse + 2 Children

☐ Self + Spouse + 3 Children ☐ Self + Spouse + 4 Children

e) Householders contents (First Loss) Fire perils including earthquake and burglary. Any valuable with value more than 5% of SI under this section to be specifically declared along with value with value otherwise will be excluded .____

18) Details of the persons to be insured

Member Details	Relationship with Proposer	DOB (dd/mm /yy)	Age	Gender (M/F)	Ht	Wt	Occupation	Net Monthly Income	Nominee	Nominee Relationship with Insured

19) Period of Insurance: From _____ To _____

20) 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____

21) Do you or any of the family members to be covered have/had any health complaints/met with any accident in the past 4 years 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 4 years	Treatment details	Date first treated	Current Status of the Illness/ Diseases/Injury

22) Has any proposal for life, critical illness or health related insurance on your life or lives ever been postponed, declined or accepted on special terms? If yes, give details

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