

[illegible]

STAR PACKAGE PROPOSAL FORM

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

Proposer Details

[illegible]

11 a) Permanent / Residential Address

House No.					House Name						
Landmark/ Locality											
Road/ Area Name											
City/District											
State					Pin Code						
Tel.											
Mobile											
Email											

11 b) Correspondence Address: (All the communications will be sent to the below address)[illegible]

- 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) Self Monthly Income :
- 17) Policy Period : ☐ 1 year ☐ 2 year ☐ 3 year

Plan Details

a) Minimum three sections to be opted. 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	Health Guard	150000	200000	300000	500000
3	Critical Illness	100000	150000	200000	300000
4	Personal Accident	200000	300000	400000	500000
5	Education Grant	200000	300000	400000	500000
6	Householders contents	100000	200000	300000	400000
7	Traveling Baggage	10000	20000	30000	40000
8	Public liability	200000	300000	400000	500000

b) Total no of sections opted for _____

c) Please select the add on covers for Health Guard section (Optional - If opted it is a mandatory cover for all)

S NO	Add on coverage on Health Guard section	Additional Premium	Please tick the option
1	Accommodation to Relative Rs. 500/- per day for 10 days	(25 %)	
2	Organ Transplant expenses of donor up to Rs.100,000/-	(25 %)	
3	Accidental Emergency, Reconstructive Surgery (In case of accident), Physiotherapy, Medical evacuation upto Rs.50,000/-	(10%)	
4	Burial, Cremation Expenses Rs.25000/-	(10%)	
5	Medical expenses for accidental hospitalization SI under health guard would double for accidental hospitalization and related surgeries	(25%)	

d) Voluntary Deductible option on Health Guard section

Deductible Amount in Rs	10,000	15,000	25,000	50,000	75,000	100,000	150,000	200,000	250,000
Please tick the opted deductible									
Discount (%)	10.00%	15.00%	17.50%	20.00%	22.50%	25.00%	27.50%	30.00%	32.50%

e) Critical Illness: Please indicate if you are option for family floater

☐ Yes ☐ No

☐ Self + Spouse

☐ Self + Spouse + 1

☐ Child Self + Spouse + 2 Children

☐ Self + Spouse + 3 Children

☐ Self + Spouse + 4 Children

f) 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.

Details of the persons to be insured

Sr No	Name	DOB (dd/mm/yy)	Age	Gender (M/F)	Ht	Wt	Occupation	Relation	Net Monthly Income	Nominee	Relation of Nominee

18) Co-Payment (Waiver for non-network Hospitals)

☐ Yes ☐ No

19) Period of Insurance: From

D D M M Y Y Y Y To D D M M Y Y Y Y

20) Do you smoke cigarettes or consume tobacco (chewing paste) / alcohol, nicotine or marijuana in any form?

Please give duration and daily consumption

21) 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

22) Have you or any of your immediate family members (father, mother, brother or sister) have/ had cancer, heart attack, or stroke and at What age?

Prior to age 60yrs?

☐ Yes ☐ No

If yes please provide details

23) Please confirm, if any of the person to be insured is pregnant (For Females Only) If yes, please state how many months?

☐ Yes ☐ No

24) 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)

☐ Yes ☐ No

25) Illness/injury details of the past 4 years and prior to 4 years.

Sr. No	Name of the person	Name of the Illness /injury suffered / suffering in the past 4 years	Treatment details	Date first treated	Name of the Illness / injury suffered any time in the past (prior to 4 years)	Treatment details	Date first treated	Current Status of the Illness/ Diseases/Injury

26) 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

27) Family Doctor Details:

[illegible]

Declaration*

1. I 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 am authorised to propose on behalf of these other persons.
2. 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 insurer and that the policy will come into force only after full payment of the premium chargeable.
3. I further declare that I 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.
4. I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.

Date ____/____/____

Place : _____

Signature/ Thumb Impression of the Proposer

Certified that the contents of the Proposal Form and documents have been fully explained to the Proposer and that he/they have fully understood the significance of the proposed contract**

Date ____/____/____

Place: _____

Signature (On behalf 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.**

Section 41 of Insurance Act 1938 as amended by Insurance Laws Amendment Act, 2015 (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 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 complying with the provisions of this section shall be punishable with fine which may extend to rupees ten lakh.

ACKNOWLEDGEMENT:

ACKNOWLEDGEMENT:
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: _____ Date: _____ Time: _____ Place: _____

Signature of Bajaj Allianz Official/ Intermediary: _____ Date: _____ Time: _____ Place: _____
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