

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) Household 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

D	D	M	M	Y	Y	Y	Y
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 To

D	D	M	M	Y	Y	Y	Y
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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 _____

Declaration*

- 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.
- 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.
- 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.
- 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.
- 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 : _____

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: _____

*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.

Signature/ Thumb Impression of the Proposer

Signature (On behalf of 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:

Received from Ms. / Mrs. / Mr: _____ through Cash# / Cheque / DD / Credit Card / Debit Card No. _____ against your proposal for Health Policy.

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

PORTABILITY FORM

PART I

- 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. Add ons/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 No.	Health ID Card number	Sum Insured	CB	Period of Insurance		First Policy inception date
					From dd/mm/yyyy	To dd/mm/yyyy	

Enclosure: Photocopy of the existing policy documents

Date

D	D	M	M	Y	Y	Y	Y
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Signature of Proposer

PART II

1. Whether the PED exclusions / time bound 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) isdays/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