BAJAJ Allianz 🕕

Relationship Beyond Insurance



For Office Use Only	y:		For Agent Use Onl	y:
Scrutiny No.	Receipt No.	Policy No.	IMD Code	IMD Name

HEALTH GUARD : PROPOSAL FORM

Instructions	For	Filling	Up	The	Form:-	
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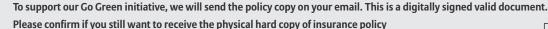
1. FIEdde di idwei di guestions in DEOCK ietters	1.	Please answer al	questions in	BLOCK letters.
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- 2. The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid.
- 3. This Proposal will be the basis of any subsequent policy that the Company issues to you. It is therefore essential that you provide all the information in this Proposal FULLY AND ACCURATELY and that you provide the Company with any and all additional information relevant to risk to be insured or its decision as to acceptance of the risk or the terms upon which it should be accepted.

Prop	oposer Detalls									
1.	Full Name: Title Middle Name		I	First Nai Surnam						
2.	Are you an existing Bajaj Allianz Customer: Y es / No	o If yes, ple	ease mention the P	olicy No	: OG					
3.	Gender: 🗆 Male 🗆 Female 🗆 Other	5 71		4. Date		DD	M	YYYY	Y	
5.	PAN No.				Jnique ID:					
7.	Bajaj Allianz Employee Code, if Proposer is BAGIC/BA	LIC Emplo	oyee							
8.	Marital Status: 🗆 Married 🗆 Single 🗆 Div	vorced 🗆	Widowed	9. No. o	f Children	So	ons[Daughters		
10.). Occupation 🗆 Business 🗆 Salaried 🗆 Pro	ofessional	🗆 Student 🗆	Hous	se Wife	□ Retire	d 🗆 Oth	ers		
11. a	. a) Permanent / Residential Address		1	l b) Co	rrespond	ence Add	ress: (All th	e communicat	ions will be sent to th	e below address)
Hou: Lanc Roac City/ State Pin C Tel.	n Code			Hou Land Roa City Stat Pin Tel. Mot Ema	Code bile bil D Post G	me				
14. 15. 17. 18.	4. In case of any Offer, you would prefer to be contacted by: Phone Email 5. Nationality Image: Contacted by: Phone Email 7. Plan: Cold Silver Cold									
19.										
20.	. Co pay Discount: □ Yes □ No (If yes please ch □ 10% □ 20% Note:If opted voluntarily by the Insured then Insured admitted under In-patient Hospitalisation Treatment	d will be e	ligible of additiona							
21.	. DETAILS OF PERSONS TO BE INSURED									
	Member Details	ionship Proposer	Date of Birth DD/MM/YYYY	Age	Height	Weight	Gender (M/ F)	Sum Insured	Nominee	Nominee Relationship with Insured

- 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
- 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



🗆 Yes 🗆 No

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.

Proposed Policy Period: From: DD/MM/YYYY , To: DD/MM/YYYY	Date:	D	D	М	М	Υ	Y	Y	

Signature of Proposer

INSURANCE ACT, 1938 SECTION 41 - 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 FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO RUPEES TEN LAKH.

Bajaj Allianz General Insurance Co. Ltd | G.E. Plaza, Airport Road, Yerawada, Pune - 411006. IRDA Reg No.: 113.

Website: www.bajajallianz.com | Call: 1800-209-0144/1800-209-5858 | CIN: U66010PN2000PLC015329 | UIN: IRDAI/HLT/BAGI/P-H/V.II/113/16-17 | E-mail: customercare@bajajallianz.co.in