Family Medicare Policy

Proposal Form

Important Instructions

Please read the instructions below carefully before filling out this form

- This Proposal Form shall be the basis of the policy to be issued. Thus, please provide all the information sought in this Proposal Form & all additional relevant information fully & accurately. **Please do not leave any space blank or put dashes.**
- The Company will not be on risk until the Proposal has been accepted by the Company and communication of the acceptance has been given to the proposer in writing after payment of requisite premium.
- Details of up to 6 Insured Persons, can be filled in this Proposal Form. For additional members, please use a fresh form.
- Pre-policy health check-up reports not older than 30 days are required to be submitted, wherever required at Company's discretion.
- A person porting (switching) from health insurance policy of other non-life insurance or stand-alone health insurance companies must complete Annexure C (Portability Form) along with Proposal Form, Annexure A and B (if required).
- List of documents required is provided in Annexure D.

I. Proposer Details

Please submit a copy of Aadhaar/Passport/Election Photo ID Card/Latest Electricity Bill/Bank Pass Book as Proof of Address

Name: _____

Date of Birth: DD/MM/YYYY Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Single ☐ Married

Occupation: ☐ Salaried ☐ Self-Employed ☐ Others, please specify _____

PAN: _____ *(Or form 60/61)* Aadhaar Card/Passport No: _____ E-Insurance Account No.: _____ *(if available)*

Address: _____

_____

City: _____ State: _____ Pin Code: _____

Tel. No.: _____ Email ID: _____ Mobile: _____

II. Nomination

Where Nominee is a minor, please give the details of Appointee

Nominee mentioned below will be for the 1st Insured. For other members covered under the Policy, the 1st insured is deemed to be the Nominee

Nominee Name: _____ Nominee Relationship with the Proposer: _____

Nominee Address: _____

Nominee Date of Birth: _____ Nominee Contact No: _____

III. Coverage Details

Coverage required from DD/MM/YYYY to midnight of DD/MM/YYYY

Policy Type: ☐ Individual Sum Insured ☐ Family Floater TPA preference: _____

Sum Insured Options: ☐ 3 Lakhs ☐ 4 Lakhs ☐ 5 Lakhs ☐ 6 Lakhs ☐ 7 Lakhs ☐ 8 Lakhs ☐ 9 Lakhs ☐ 10 Lakhs ☐ 15 Lakhs ☐ 20 Lakhs ☐ 25 Lakhs

Daily Cash Allowance (Opt.): ☐ Yes ☐ No Maternity Expenses and New Born Baby Cover (Opt.): ☐ Yes ☐ No

IV. Insured Person(s) Details

Paste one stamp size photograph and sign below. In case of minor, guardian or proposer may sign

1st Insured Person's Photo	*2nd Insured Person's Photo*	*3rd Insured Person's Photo*	*4th Insured Person's Photo*	*5th Insured Person's Photo*	*6th Insured Person's Photo*
Signature	*Signature*	*Signature*	*Signature*	*Signature*	*Signature*

	1st Insured Person	2nd Insured Person	3rd Insured Person	4th Insured Person	5th Insured Person	6th Insured Person
Name						
Date of Birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Gender	☐ M ☐ F ☐ O	☐ M ☐ F ☐ O	☐ M ☐ F ☐ O	☐ M ☐ F ☐ O	☐ M ☐ F ☐ O	☐ M ☐ F ☐ O
Marital Status	☐ Single ☐ M	☐ Single ☐ M	☐ Single ☐ M	☐ Single ☐ M	☐ Single ☐ M	☐ Single ☐ M
ABHA ID						
Occupation						
Aadhaar No.						
Sum Insured						
Height (cm)						
Weight (kg)						
Blood Group						
Relation w/ Proposer						
Dependent	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

ABHA Creation Declaration: I declare that I have read the terms of usage of Aadhar for creation of ABHA Number as available at https://healthid.ndhm.gov.in/register/aadhaar. I consent to the usage of my/our Aadhaar Number(s) by UIIC for creation of my/our ABHA number(s) through National Health Authority (NHA). ☐ Yes ☐ No

V. Existing Health Cover Information

Does any person proposed to be insured presently hold a health insurance policy from any insurer (including UIIC)? ☐ Yes ☐ No
If yes, please give details below.

	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6
Company						
Policy No.						
Policy Type (Base/ Top-Up)						
Expiry Date						
Sum Insured						
Servicing TPA						
Last Claimed Date						
Claimed Amount						
Porting/Migrating						

Kindly fill Annexure C if insured is porting from another insurance company to our company.
Please note that the continuity of benefits shall NOT be considered if the above question is not replied in the affirmative, details are not provided and Portability Form (Annexure C) and relevant supporting documents are not submitted to UIIC.

VI. Medical Information

Medical History of the person proposed for Insurance. Tick Yes/No. Please do not leave the spaces blank.

	Insured 1	*Insured 2*	*Insured 3*	*Insured 4*	*Insured 5*	*Insured 6*
Are/Is you/the person proposed for insurance in good health and free from physical and mental disease or infirmity or medical complaints	Y N	Y N	Y N	Y N	Y N	Y N
Lifestyle Questionnaire Does any person who is proposed for insurance consume						
Alcohol						
Tobacco (Cigarette/Bidi/Gutkha/Pan Masala, etc.)						
Illegal Drugs						

If the answer is 'Yes' to any of the questions above, please give details below on the type and quantity consumed per week and consumption history (years)

- Alcohol –
- Tobacco (Bidi/Cigarette/Gutkha/Pan Masala, etc.) –
- Illegal Drugs –

Specific Condition Questionnaire - I Does any person who is proposed for insurance ever suffered from/are suffering from any of the following: Please provide details in the table below.						
Genetic Disorder, Malignant Cancer, Permanent Recurring Condition, HIV/AIDS	Y N	Y N	Y N	Y N	Y N	Y N
Acid Attack, Anaemia, Asthma, Blindness, Mental illness Diabetes Mellitus, Hypertension, Renal stones Epilepsy, Chronic neurological conditions, Parkinson's Disease, Multiple Sclerosis, Muscular Dystrophy, Cerebral palsy Sickle Cell Disease, Thalassemia, Haemophilia Low vision, Hearing Impairment, Dwarfism, Autism Spectrum disorder, Leprosy cured person Specific Learning Disability, Speech & Language Disability, Intellectual disability, locomotor disability	Y N	Y N	Y N	Y N	Y N	Y N
Specific Condition Questionnaire - II Does any person who is proposed for insurance ever suffered from/are suffering from any of the following: Please provide details in the table below						
Any disorder/ disease of the stomach, Intestine, Liver, Gall bladder, Pancreas, Kidney (except Renal Stones), Urinary Bladder, Urinary Tract	Y N	Y N	Y N	Y N	Y N	Y N
Blood Disorder, Venereal Diseases (other than above), Hyperthyroidism, Hypothyroidism, Dyslipidaemia (High cholesterol)	Y N	Y N	Y N	Y N	Y N	Y N
Cataract or other diseases of the eye	Y N	Y N	Y N	Y N	Y N	Y N
Critical Illness, Recurring Illness or Chronic Illness	Y N	Y N	Y N	Y N	Y N	Y N
Disease of Bones/ Joint including arthritis, rheumatic pain, slipped disc, spinal disorder, injury to Ligaments or Paralysis	Y N	Y N	Y N	Y N	Y N	Y N
Disease of Fistula/Prostrate, Piles, Hernia, Varicose veins	Y N	Y N	Y N	Y N	Y N	Y N
Disease of Cardiovascular system, heart disease (Chest Pain, Coronary Insufficiency, Myocardial Infarction, etc.)	Y N	Y N	Y N	Y N	Y N	Y N
ENT Disease, Respiratory or Allergic Disease (Tuberculosis, Bronchitis, Pneumonia, COPD etc) other than Asthma	Y N	Y N	Y N	Y N	Y N	Y N
Gynaecological disorder such as DUB, Fibroid Uterus, Prolapsed Uterus, Ovarian cyst or breast or any specific gynaecological disorders or have undergone caesarean/ Hysterectomy	Y N	Y N	Y N	Y N	Y N	Y N
Disease of Central Nervous System (other than those mentioned in Specific Condition Questionnaire)	Y N	Y N	Y N	Y N	Y N	Y N
Psychiatric Disorder (other than those mentioned in Specific Condition Questionnaire), Thyroiditis/Goitre	Y N	Y N	Y N	Y N	Y N	Y N
Benign Tumor, Pre-cancerous Lesion, Ulcer, boil, cyst or wound etc. which does not heal or improve despite treatment	Y N	Y N	Y N	Y N	Y N	Y N
Other Medical Questionnaire Does any person who is proposed for insurance ever suffered from/are suffering from any of the following: Please provide details in the table below						
More than two Hospitalization in the previous two years except for hospitalizations for vector-borne, air-borne, and water-borne diseases with hospitalizations less than 5 days. Or Any Surgery/Treatment, consultations, investigations, or diagnostic tests planned or pending	Y N	Y N	Y N	Y N	Y N	Y N
Experienced pain for more than 7 days in any part of the body OR restriction of any movement OR difficulty in swallowing or breathing OR any difficulty in carrying out your daily activities? Or Persistent headache or persistent cough OR blood in stool or any bleeding from any other orifice/ body opening for more than 5 days?	Y N	Y N	Y N	Y N	Y N	Y N

If you answered 'Yes' to any of the prior questionnaires, please give details in the following table. Additionally, also submit Annexure A, B.

Name of the Person to be insured	Illness(es)	Date of Last Consultation (DD/MM/YYYY)	Treatment(s) Undergone	Name of the treating Doctor	Hospital Name & Phone No.	Present Status

Past Proposals

Has any proposal for life, health, or critical illness insurance for any of the persons proposed to be insured ever been declined, postponed, loaded, or made subject to any special conditions by any insurance company? ☐ Yes ☐ No

VII. Payment Details

Premium Amount (₹): _____ (in words) _____

Premium Payment Modes: ☐ Cash ☐ Cheque ☐ DD ☐ Credit/Debit Card ☐ ECS Cheque/DD No.: _____ Date: DD/MM/YYYY

VIII. Bank Details for Processing of Refund

Bank Name: _____ Branch Address: _____

Bank Account No: _____ IFS Code: _____

IX. Declarations

☐ 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 authorized 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 requisite receipt.

☐ 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.

☐ Ayushman Bharat Health Account (ABHA) Declaration: I authorize the company to access my/our information as available in my/ our Ayushman Bharat Health Account (ABHA) including the medical records for the sole purpose of proposal underwriting and/or claims settlement and share the same with TPAs, Service Provider(s) of UIIC and/or any Governmental and/or Regulatory authority and/or to comply with the applicable Law/ Regulations.

I also confirm that the source of funds for premium paid under this policy is legal.

Date: DD/MM/YYYY Place: _____ Signature of the Proposer: _____

Name of the Proposer (in BLOCK letters): _____

X. Certificate from Proposer in case Proposal form is not filled by them/The proposer signs in vernacular language/is illiterate

(As required to comply with clause no. 6 (4) of Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017)

The proposal form is filled up by my representative, but the contents of the documents have been fully explained to me and I am willing to accept the coverage subject to terms, conditions and exceptions prescribed by the Insurance Company therein.

Date: DD/MM/YYYY Place: _____ Signature of the Proposer: _____

Name of the Proposer (in BLOCK letters): _____

Please note that this should necessarily be signed by the proposer and not by his/her representative.

XI. Declaration of the Intermediary

I/We confirm that I/We have explained the product features to the proposer and its suitability to him/her and other insured persons.

Date: DD/MM/YYYY Place: _____ Signature of Intermediary: _____

XII. Statutory Warning (Section 41 of Insurance Act, 1938 – 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 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 or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the Insurers.
- Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

XIII. Office Use Only

Gross Premium: _____ Premium for Optional Cover: _____ Net Premium: _____

Intermediary Code: _____ Development Officer Code: _____

Acknowledgement by the Company

Date: DD/MM/YYYY

We acknowledge the receipt of your proposal and amount by Cash/Cheque/Others _____ for amount of Rs. _____

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions, and we shall have no liability to make any payment if premium is not received by us in full and in time or is not realized. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.

This Annexure is to be completed by EACH insured person who has answered 'Yes' to any of the questions in Section V (Medical History) or has any pre-existing conditions/adverse history in respect of any illness.

Name of Insured Person: .....

Diabetes Questionnaire

- Date of 1st Diagnosis of Diabetes : .....
- Do you take any anti-diabetic drugs? If so, please give name with dosage : .....
- Please give details of fasting and postprandial blood sugar readings, E.C.G. findings & other investigation reports with date. Please also send reports : .....
- Please state whether you have been diagnosed with any complication of diabetes? : .....

Hypertension Questionnaire

- Date of 1st Diagnosis of Hypertension : .....
- What is your blood pressure reading? Please state with dates : .....
- Please state names of anti-hypertensive drugs with dosage details : .....
- Are you a smoker? : .....
- Is it essential/secondary/malignant hypertension? : .....
- Please state whether you have been diagnosed with any complication of hypertension? : .....
- Please give findings of all investigation reports : .....

Chest Pain or Coronary Insufficiency or Myocardial Infarction Questionnaire

- Date of 1st Diagnosis Did you ever suffer from chest pain/coronary insufficiency/myocardial infarction? If so, please give diagnosis and date. : .....
- Please state the name and dose of drugs you are taking at present : .....
- Please state the findings with dates of investigations done like ECG, Stress Test, coronary angiography, X-ray, pathology reports, etc. Please send reports with the proposal form. : .....
- Please state the date of hospitalisation and names of hospitals (attach last discharge summary) : .....
- Please state complications and other related disease, if suffered. : .....
- Please state whether you can do your regular work and whether you have any limitation of activity? : .....
- Are you advised any special treatment? If so, please give information : .....

Any other Pre-Existing Condition

- Nature of illness/disease/injury & treatment received : .....
- Date of 1st Diagnosis : .....
- Whether fully cured? : .....
- Please state the date of hospitalisation and names of hospitals. (attach last discharge summary) : .....

Date: DD/MM/YYYY Place: ..... Signature of Insured Person: .....

This Annexure is to be completed by the consulting physician/surgeon if ANY of the insured persons have answered 'Yes' to any of the questions in Section V (Medical History) or have any pre-existing conditions/adverse history in respect of any illness.

- Name of the Insured Person :

History

- Present complaints and investigation, if any? :
- Any past history of disease, operations, accidents, investigations with date, major medical complaints of hospitalisation? :
- Details of present and past medication with duration :
- Is he/she cured of diseases, if any? When was your treatment, if any, given, stopped? :
- General Examination :
- Systematic Examination :

Signature of Consulting Physician **Signature of Proposer**

Name of Consulting Physician: **Place:**

Qualifications: **Date:** DD/MM/YYYY

Address:

Telephone No:

Office Use Only

Do you consider the risk acceptable?

Competent Authority:

At Operating Office:

At Regional Office (If referred to RO):

This Annexure is to be completed by the policyholder who is porting from a health insurance policy issued by another insurance company

Name of Policyholder: _____

Policy No: _____

PORTABILITY FORM

1.	**Name of the Insured(s)**	
2.	**Date of Birth**	
3.	**Address of the Policyholder**	
4.	**Details of Existing Insurer**	
	a. Name of insurance company	
	b. Sum Insured	
	c. Cumulative Bonus	
	d. Add-ons/riders taken	
	e. Policy Number	
5.	**Details of the Proposed Insurance**	
	a. Name of the product proposed/intended to take	
	b. Sum Insured proposed	
	c. Whether Cumulative Bonus to be converted to an enhanced sum insured	
6.	**Reason(s) for Portability**	
7.	**No. of family members to be included in the policy to be ported**	
Enclosure: Photocopy of the existing & previous policy documents		
Date: **Signature of the Policyholder**		

- Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy? (Please indicate Yes / NO):

  _____

- If Yes, please give written consent to the declaration below:

I am aware that the waiting period for the following disease(s)/treatment(s) is more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s).

Name of the Disease / Treatment	Waiting Period in Days / Years
1. 2. 3. 4.	

Date: DD/MM/YYYY Place: _____ Signature of Policyholder: _____

This Annexure details the list of documents that are required along with this proposal form and the documents that are considered as valid.

Documents Required

- Completed Proposal Form
- Cancelled Cheque (supporting bank account details)
- Stamp Size Photograph (2 no.) for each insured person
- Pre-Policy Check-up reports (if applicable)
- Copy of existing health insurance policies (if applicable)
- Proof of Identity (any one document listed below)
- Proof of Residence (any one document listed below)
- PAN Details (In case PAN not available, Form 60 or 61 as per Rule 114B of the Income-Tax Rule, 1962 must be submitted)

Documentary Proof

Features	Documents
Proof of Identity	i. Passport ii. PAN Card iii. Voter's Identity Card iv. Driving License v. Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer vi. Aadhaar Card vii. Job card issued by NREGA duly signed by an officer of the State Government
Proof of Residence	i. Passport ii. Driving License iii. Aadhaar Card iv. Voter's Identity Card v. Job card issued by NREGA duly signed by an officer of the State Government vi. Letter issued by National Population Register containing details of name and address Where the above documents do not have the updated address, the following documents shall be deemed to be valid documents for the purpose of Proof of Residence. i. Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone, piped gas, water bill) ii. Property or Municipal Tax receipt iii. Pension or family pension payment orders (PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address iv. Current Photo Passbook with details of permanent/present residence address (updated up to the previous month) v. Current statement of bank account with details of permanent/present residence address (as downloaded) vi. Ration card vii. Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof viii. Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)
Proofs of both Identity and Residence	Written confirmation from the banks where the proposer is a customer, regarding identification and proof of residence