Please give duration and daily consumption \_



## **Bajaj Allianz General Insurance Company Limited**

Regd. & Head Office: GE Plaza, Airport Road, Yerwada, Pune - 411006.

For Office Use Only :									For Agent Use Only :																								
Scrutiny No.	tiny No. Receipt No. Policy No.							Loa	an Ac	cou	nt N	umb	er	IMI	) Co	de	Su	b IM	ID Co	ode	IIV	1D Na	ame		Mob	ile l	No.		Emp	/LG	Cod	e	
						FA	МІ	LY	LC	ATI	ER	HE	ALT	TH (	GU	ARI	D -	PR	OP	OS	AL	FO	RM										
Please answe																																	
<ol> <li>The Liability of the Liabil</li></ol>	will be the	basis o	fany	sub	sequ	ent p	olicy	that v	ve iss	sue to	you.	Itist	heref	ore e	ssent	ial th	at yo	u pro	vide	all th	e info	rmat	ion in							URAT	ELYa	nd th	nat
you provide us with Proposer Deta	•	ladditic	onali	ntor	matio	on re	levar	it to ri	sk to	be ins	sured	orou	ur de	cision	as to	acce	ptan	ce of	the ri	isk or	the te	erms	upon	whic	h it s	hould	l be a	ccep	ted				
1) Full Name: T			1													F	irst	Nam	ie		1				1		1	1	1	Ī	1	1	
	∕liddle Na	ame	1															ame	-											L			
2) Are you an ex	isting Baj	aj Allia	nz (	Cust	ome	er: Ye	es /	No	If ye	s, ple	ase	men	tion	the	Polic	y No	o: O0	ŝ															
3) Gender: Mal	_	emale	_		Othe	_	7		•									of E	Birth	:	D	D	M	M		Υ	Y	Υ	Υ				
5) PAN No.			Ī													6)	UID/	/Unic	que l	ID :					Ī _								
7) Bajaj Allianz En	nployee (	Code, if	f Pro	pos	er is	BAG	SIC/E	BALIC	Emp	oloye	e:																_						
8) Marital Status	: 🗆 N	1arried	ı [	Si	ingle	. [	Div	orce/	d		Wi	dow	ed	·		9) ا	No.	of Ch	nildr	en		Son	ıs				Da	ugh	ters				
10) Occupation :		usines								onal		Stu	dent	: [	Нс	use	Wife	ē		Reti	red		] 0	thers	 5								
11a) Permanent	/ Resider	ntial Ad	ldre I	SS :		ı	ı	ı	ı	1 1		ı	ı		ı		ı	ı		ı	ı	ı	ı	1	1	1	1	ı	1	1	1	1	
House No & Nam	ne	Щ	_	_						Ш										L					<u></u>		<u></u>	_	_	$\perp$	<u> </u>	_	_
Landmark/Locali	ty		4					_		Ш		_								<u> </u>		_	_		_		<u> </u>	_	_	_	_	_	$\Box$
Road/Area Name		Ш	_													Ci	ity			L								_		Ļ		Ļ	
State																																	
11b) Correspond	1	dress :	(All	the I	com	ımuı I	nicat I	ions I	will I	be se	ent t	o the	e bel	ow a	iddre I	ess)	I	ı	ı	ı	ı	l	ı	ı	ı	ı	ı	ı	ı		ı	1	
House No & Nam	ne		4			<u> </u>	<u></u>		<u> </u>			<u></u>	<u> </u>		<u> </u>		<u> </u>			<u> </u>		<u>                                      </u>			<u>                                       </u>	<u>                                     </u>	<u> </u>	<u> </u>		_	<u> </u>	+	_
Landmark/Locali	ty	Ш																		L													
Road/Area Name	<u> </u>															Ci	ity																
State																								Pi	in C	ode							
Telephone (Res.)										Telephone (Office)																							
Mobile Number											E-	Mail												(	@ _								
12) Educational (	Qualificat	ion:	M	latri	cula	te		Und	er G	radua	ate		Grad	luate	: _	Pos	st Gı	radua	ate	F	rofe	ssio	nally	Qua	lifie	d							
13) Family Month 14) In case of any	,	_			Rs.				-	. 20,0			. 50,	000 Em	ail			0,00		1	1 lak 	h 	$\Box$	Abo 	ve F	Rs. 1	lakh 	ı	1	ı	I	ı	
16) Sum Insured					acs.	be			acs		_	4 Lac		, EIII	_	Lacs	) iva	tiona		Lacs		_	10 L	200									
Details of the			e Ir					3 1	_acs			4 Lat	-5		] 3	Lacs			7.5	Lacs	Į.		10 L	acs									
Details of the	person			Ju																			1						T				
S. No.	N	lame					ı	DOE d/mm,		A	ge	Ger (M	lder /F)	H	t.	W	t.		Occ	cupa	tion				Rel	atio	n			Ass	ingn	ee	
																													Ť				_
															$\dashv$		$\dashv$						-						+				_
																													╧				
																	$\exists$												$\dagger$				_
															$\dashv$		$\dashv$						-						+				_
																													$\perp$				
16) Period of Ir	nsurance	e : Fro	m [			Π	$\vdash$	Τ		$\vdash$			 _	$\top$	十	T	寸	T	$\overline{}$	T	$\overline{}$												_
17) Co-Paymen	t (Waive	er for	non						•				lo □							_													

70de - 100000	1000000
IMD	- IMIC
Downloaded from www incureatelists com	Cowingated from www.mistalcatemer.com

	any kind, diab nervous syster table given be	m, fit																															
	Please confirm If yes, please st								sur	ed is	pre	egna	nt (F	or F	ema	les (	nly	)												] Y	es [	No	
21)	Do you or any of past 4 years an ( Please provid Illness/injury of	of the d hav de de	e fa ve k tail	mily been s in t	mer taki he t	mbe ing t able	ers to treat e give	be mer en b	nt/ł elov	nosp w)	ital	lizati	on?	ny h	nealt	h co	mpla	aints	s/n	net w	ith a	any ac	 ccid	enti	n th	ie				] Ye	es [	□No	
Sr. No.	Sr. Name of the person injury su					Name of the Illness /					Treatment deta				te first eated	t	Name of the Illness / injury suffered any time in the past (prior to 4 years)					e in 7	reat	ment	t det	tails		Date f treat		c	Current Status of the Illness/ Diseases/Injury		
																														<u>+</u> +			
	Has any propo terms? If yes, g				ritic	al il	Iness	s or	hea	ılth r	ela	ted i	nsur	ranc	ce on	you	ır life	e or	live	es ev	er b	een p	oost	pon	ed,	dec	line	d or	acce	pte	d or	specia	
24)	Family Doctor	Detai	ils:				1	1		1	_					1	1	1	1		1	1 1						_					
	Name:	Ш									$\vdash$	+			+					<u> </u>								Ļ	Щ				
	Qualification:	Щ					<u> </u>				Ļ	<u> </u>		<u> </u>	$\perp$						Mob	ile No	): 					뉴	Щ				
	Address:	Щ						Ļ			L																	$\perp$					
	Reg No:																																
Vol	luntary Deduc	tible																															
Dedu	uctible Amoun	t in F	₹s	Plea	se t	ick	the o	pte	ed d	edu	ctib	ole D	isco	unt	<u>(%)</u>			_			_			_						_			
Ded	uctible Amoun	t in F	₹s			10	,000		1	5,00	0	2	25,00	00	5	0,0	00	7	75,	000		100,0	000		150	0,00	0	200	0,000	)	25	0,000	
Plea	se tick the opt	ed de	edu	ıctib	le																												
Disc	ount (%)					10	.00%	5	1	5.00	%	1	7.50	0%	2	20.00	)%	2	22.	50%		25.00	)%		27.	50%	6	30.	.00%		32	.50%	
I/we agree that be co Com may a polic	aration declare that the that this declare that this declare that this declare that the pany addition onveyed to the pany Ltd and/cattend in future, y, subject to the chas been declarance	arations or an ending a second	on: alte aj A of icei s, e	shall ratio Ilian its a rning exclu	form ons a z Ge outhor g any sion	m thare or ener oriz y dis	ne ba carrie ral li ed re sease nd co	ed o nsur epre or i	of thut a rand sen illne tion	ne co ofter ce Co tativ ess. I	ontrontrontrontrontrontrontrontrontrontr	ract k e sub pany to se rther ribec	etwomis Ltd ek n dec	veer sior im ned clare erei	n me, n of tl imed lical in ed tha in an	/us a his p iate nfor at I h d fu	and I ropo ly. I mat ave urthe	Baja osal furt ion f reac er di	j al fo he fro d th scl	llianz orm ar er cor m an ne pro lose	Ger nd/onsen ny ho ospe that	neral or iss t and spita ctus con t	Insusuar I au I/m and the	urand nce of thor edic I hav ever	ce C of po ize al p e ur nt o	Compolicy Baja ract nder f fir	pan do aj al itio sto ndin	y.Ltd cum lianz ner v od th	I I / ent, t Gen who I ne sai y th	we sthe state that the state that th	also sam I In atte I ac con	declar e woul suranc nded c cept th	
Place	ş;			Т				Т							Sign	atur	e of	Pror	าดร	ser													
Date															Nam					L													
No per respense premallow OF TH Certi	erance Act, 1938 erson shall allo ect of any kind nium shown on yed in accordar HIS SECTION SH fied that the erstood the sig	ow or l of ri n the nce w HALL l con	off isk po /ith BE ter	er to relati licy, the PUN ots o	allo ting nor: pub ISHA f th	to l sha olish ABL e P	eithe lives II any ned p E WI' ropo	er di or p pe rosp TH F sal	rectorop rsor pectorop INE For	tly or perty n tak tus o WH m a	r ind ing ing or ta ICH and	India out ables IMA doc	or re of the	ny ro ene he i TEN ents	ebate wing nsure ID TO have	e of or o er FIV e be	the conti ANY EHU en f	who nuir PER INDI ully	ole ng RSC REI e:	or pa a pol DN M. D RUI	art o licy a AKIN PEES ned	of the accep NG FA S. to t	e co et ar NULT	mmi ny re Γ IN (	issio bat CON	on p e, e) //PL\	aya kcep /IN(	ible o pt su G WI	or an ch re TH TI	ny re ebat HE F	ebat e as PRO	e of th may b /ISION	
ridCe															Sign	atur	e (C	אט וויי	z116	ali Of	rio	Joser	1										
Date	:														Nam	ie				$\top$	Τ		_					$\overline{}$		_			

Disorder of the heart, or circulatory system, chest pain, high blood pressure, stroke, asthma any respiratory conditions, cancer tumor lump of

 $19) \quad \text{Has any of the persons to be insured suffer from/or investigated for any of the following?} \\$ 

<sup>\*\*\*</sup> This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer.

 $<sup>{\</sup>tt **Please}\ \ read\ declaration\ wordings\ carefully\ before\ signing\ \ the\ proposal\ \ form.$ 

## **Portability Annexure**

## Please fill this form if Portability is opted

Reason for Por	Reason for Portability																									
Are there any add ons or riders in the previous coverage																										
Whether CB no	eeds to be c	onverted to	the er	nhan	ced SI																					
Past Insuran	ce Details																									
(Please attac	h a policy co	opies as de	clared)																							
First Name	Nan	ne of	Deta	ils of	Previo	ous H	ealth	1	Health ID		`	lnauraa		СВ	Р	erioc	of	Insura	nce	F	Policy					
of Insured	Insurance	nce l	Policy	/ Poli	cy No	o.	Card numbe	r	bum	Insured		_D	dd	From /mm/yy	l yyy	To dd/mm	) /yyyy	inc	inception dat							
						1		t							$\neg$			$\vdash$								
						+		+										$\vdash$								
										+										$\vdash$						
																				$oxed{oxed}$						
								T																		
								+		$^{+}$							$\dashv$			+						
								+		+										$\vdash$						
CLAIM DETAILS UNDER PREVIOUS POLICIES TILL DATE																										
S. No.	imed for			Δ	mour	nt of	Clair	n			Pol	Policy No.														
	11136114411	ne of Insure		_		7 (111						,			Ciuii		POlicy No.									
														+												
				+												+										
																+										
																	$\perp$									
Whether the F	Pre-Existing	Exclusions	/ time	bour	nd exc	usio	ns ha	ve	longer excl	usi	on p	eriod t	han tl	he ex	cistin	g po	licy	□ Ye	es /		NO					
If yes Please g	ive the writ	ten declara	ition as	belo	w																					
Declaration																										
I am aware that			-existin	g dise	eases /	time l	oound	d ex	clusions is			\	ears n	nore t	hant	he pr	evio	us poli	cy ter	ms. I	here	by agree				
to observe the a		• .	/ me/us	in thi	s nrond	sal fo	nrm ai	re tr	rue and to th	e h	est o	of my /	nur kna	owled	lge ai	nd he	lief a	nd I/w	e heri	ehv a	gree	that this				
declaration shall	form the bas	is of the cont	ract betv	ween	me/us	and B	ajaj al	llian	ız General In:	ura	ance (	Compan	y.Ltd	I / we	also	declar	re tha	at if any	y addit	tions	or al	erations				
are carried out a																										
information fron					-	-												-								
prospectus and h																										
finding any thing under this insura		wnat nas bee	en decia	rea b	y me, i	snaii	be ne	ia r	esponsible to	or a	II cor	isequen	ces the	ereor	and i	nsura	nce (	compai	ny sna	all inc	cur no	паршту				
Place:									Signature	of	Prop	oser														
			]																_	T						
Date:			_						Name and	d D	esigr	nation														
Insurance Ad	t, 1938 Sec	tion 41 - Pr	ohibiti	on of	f Reba	tes																				
No person shall a																						-				
of risk relating to person taking ou																										
the insurer AN	_			-				-			-						-			-						
HUNDRED RUPE															. /							•••				
Certified that the of the proposed		me Proposa	ı rorm a	iiu ac	cumen	ıs nav	ve pee	en Tl	uny explaine	u (C	ıne	rropose	r and t	ınat h	ie/th	ey na\	re IU	ily und	erst00	ou th	ie sigi	iiiicance				
					, ,			1																		
Place :									Signature	(Oı	n bel	half of Propose							_							
Date:									Name						T				$\top$	T						

 $<sup>***</sup> This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer. \\ **Please read declaration wordings carefully before signing the proposal form.$