THE NEW INDIA ASURANCE COMPANY LIMITED

Regd. & Head Office : *New India Assurance Bldg., 87, M.G. Road, Fort, Mumbai–400 001*

PROPOSAL FORM FOR HEALTH PLUS MEDICAL EXPENSES POLICY.
INDIVIDUALS

Please read the prospectus before filling up this form.

A) The Company shall not be on risk until the proposal has been accepted by the Company and communications of acceptance has been given to the proposer in writing on full payment of premium.

B) For persons above 45 years of age, pre-acceptance health check up will be conducted at a designated diagnostic center. A referral slip will be given by the Divisional Office/Branch Office in the name of diagnostic center for conducting the pre-acceptance health check up. The details of the check up is available with the Divisional Office/Branch Office.

C) Separate detail information should be given for all the persons proposed to be covered under the policy.

D) Fresh proposal form is required along with pre acceptance medical check up as mentioned in item 3 irrespective of age when there is break of more than 15 days in insurance cover or when there is request for enhancement in the sum insured.

E) **Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy issued.**

1. NAME OF PROPOSER : Mr/Mrs._____

2. RESIDENTIAL
ADDRESS:_____

Tel.No:_____Fax No. E-Mail:____

3. Occupation:_____

4. Average Monthly Income Rs._____ Income Tax Pan No:_____

5. NAME, ADDRESS & TE.NO: OF FAMILY PHYSICIAN_____
_____
QUALIFICATION:_____ REG .NO: _____

6. Are you at present or have you been at any other time in the past covered under any other Insurance (PA, Cancer Insurance, Hospitalization Insurance or other Medical Insurance). If so, give particulars of:

1. Name of Insurer,
2. Policy No.
3. Period of cover
4. Claim Amt. Recd./receivable

7.Any proposal for this Insurance or any other similar insurance refused or cancelled or higher premium charged. If so, give details:

8.DETAILS OF PERSONS TO BE INSURED:

Sr. No:	Name of all the person	Date of Birth	Age	Sex (M/F)	Relation with the Proposer	Sum Insured selected	Signature:
1							
2							
3							
4							
5							
6.							

9.Do you wish to opt insurance under Section II_____

MEDICAL HISTORY: Please answer the following questions with Yes or No (A dash is not sufficient and give full details in respect of all the persons to be insured)

1 2 3 4 5 6 7

1) Are you in good health and free from physical and Mental disease or infirmity.

2) Have you ever suffered from any illness or disease upto the date of making this proposal.

3) Do you have any physical defect or deformity

4) Have you ever been admitted to any hospital/ nursing home/clinic for treatment or observation

5) Has any of the persons proposed for insurance has suffered from any illness/disease or had an accident in the past. If so, give details as under:

Sr.No:of Persons	Nature of illness/disease/injury & treatment received	Date on which first treatment taken	First treatment completed/is continuing	Name of attending medical practitioner/surgeon with his address & tel. Nos.
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Note: This information should be given for any of the persons proposed for insurance, if he/she had suffered from any illness/disease injury, please give details separately.

6) Are there any additional facts affecting the proposed Insurance which should be disclosed to insurers? If yes, then give details below:

7) Please give details of any knowledge of any positive existence or presence of any ailment, sickness or injury which may require medical attention? If yes, then give details below:

8) Name of the Assignee- Relationship

9) Period of Insurance: From_____ To _____

10) Declaration: I declare that the persons proposed for insurance are my family members and they are not engaged in high risk occupation. I also declare that none of them suffer from any pre-existing conditions and that I have given explicit information of such sickness/disease/injury sustained in the above columns where the information has been sought. I further declare that the above statements in respect of myself and my family members, are true and complete. I consent and authorize the insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended me or my family members or may attend concerning any disease or illness which affects my or my family members, physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be affected. If after the insurance is affected, it is found that the statements, answers or particulars stated in the Proposal form and its Questionnaires are incorrect or untrue in any respect, the Insurance Company shall incur no liability under this insurance.

I have read the prospectus and am willing to accept the coverage subject to the terms, conditions and exceptions prescribed by the Insurance Company therein.

Signature of the Proposer:_____Date: _____/_____/_____
DD MM YY

Place:_____

41 Section/41 of Insurance, Act, 1938
Prohibition of Rebates

1) No person shall allow or offer to allow either directly or indirectly as an inducement of 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 or continuing a policy except any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the insurer.

2) Any person making default in complying with the provisions of this Section shall be punishable with fine which may extend to five hundred rupees.

For Office Use:

Basic premium under Section I for each of the insured person covered		Rs.
Less: Family Discount		Rs.
Premium under Section II	(If opted)	Rs.
Plus: Service Tax		Rs.

(Family discount is not available to dependent parents premium when they are above 60 years of age under Section I)

THE NEW INDIA ASURANCE COMPANY LIMITED

Regd. & Head Office : *New India Assurance Bldg., 87, M.G. Road, Fort, Mumbai–400 001*

PROPOSAL FORM FOR GROUP HEALTH PLUS MEDICAL EXPENSES POLICY

(TO BE COMPLETED BY THE GROUP PROPOSING FOR INSURANCE)

R.O./D.O./B.O.

Agency Code: Annual Premium

Policy No. Inspector Code

IMPORTANT

a. The company will not be on risk until the Proposal has been accepted by the Company and full premium paid by CHEQUE.
b. Employee's/Member's Personal Statement Form should be completed by each employee/member for himself/herself and his/her eligible family members, as per Annexure.
c. Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy issued.

PROPOSER DETAILS

1. Name of the Proposer
   (Capital letters)
2. Description of the Proposers business

3. Address for communication
   Tel.No: Fax No: E-mail Add.

4. No. of persons to be covered (list of
   Persons for each Sum Insured opted as per table)

   SUM INSURED
   (In Words)

5. Please state whether all eligible members of the
   Group are Proposed for Insurance.
6. Do you wish to opt insurance under Section II - Yes/No
7. Do you require Maternity Expenses: Yes/No
   Benefit Extension(stike out whichever is
   Not applicable)

1. Period of Insurance: From
   To (midnight)

Signature of the Proposer

Place:
Date:

41 Section/41 of Insurance, Act, 1938
Prohibition of Rebates

1) No person shall allow or offer to allow either directly or indirectly as an inducement of 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 or continuing a policy except any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the insurer.

2) Any person making default in complying with the provisions of this Section shall be punishable with fine which may extend to five hundred rupees.

GROUP HEALTH PLUS MEDICAL EXPENSES POLICY
EMPLOYEE'S/MEMBER'S PERSONAL STATEMENT FORM

(To be completed by Employee/Member in respect of himself/herself and his/her eligible family members proposed to be covered

1.Details of Employees/Members including family members proposed for insurance :

S. No:	Details of Employee/Member and eligible family members	Date of Birth	SEX	Occupation	Relationship to the Employee/Member	Monthly Income	
1. 2. 3. 4. 5. 6. 7.							

2.Residential address of the Employee/Member :

3.Name, Address & Tel.No: of family physician

Qualification Registration No:

4.MEDICAL HISTORY: Please answer the following questions with Yes or No (A dash is not sufficient and give full details in respect of all the persons to be insured)

1 2 3 4 5 6 7

1) Are you in good health and free from physical and Mental disease or infirmity.

2) Have you ever suffered from any illness or disease upto the date of making this proposal.

3) Do you have any physical defect or deformity

4) Have you ever been admitted to any hospital/ nursing home/clinic for treatment or observation

5) Has any of the persons proposed for insurance has suffered from any illness/disease or had an accident in the past. If so, give details as under:

Sr.No:of Persons	Nature of illness/disease/injury & treatment received	Date on which first treatment taken	First treatment completed/is continuing	Name of attending medical practitioner/surgeon with his address & tel. Nos.
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Note: This information should be given for any of the persons proposed for insurance, if he/she had suffered from any illness/disease injury, please give details separately.

5.Are there any additional facts affecting the proposed Insurance which should be disclosed to insurers? If yes, then give details below:

6) Please give details of any knowledge of any positive existence or presence of any ailment, sickness or injury which may require medical attention? If yes, then give details below:

7) Declaration: I declare that the persons proposed for insurance are my family members and they are not engaged in high risk occupation. I also declare that none of them suffer from any pre-existing conditions and that I have given explicit information of such sickness/disease/injury sustained in the above columns where the information has been sought. I further declare that the above statements in respect of myself and my family members, are true and complete. I consent and authorize the insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended me or my family members or may attend concerning any disease or illness which affects my or my family members, physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be affected. If after the insurance is affected, it is found that the statements, answers or particulars stated in the Proposal form and its Questionnaires are incorrect or untrue in any respect, the Insurance Company shall incur no liability under this insurance.

Signature of the Employee/Member for himself/herself &/or on behalf of other family members to be covered
_____

Date: _____/_____/_____

Place:_____