

To help us serve you better, kindly ensure that the form is completely filled. (This Insurance does not commence until the proposal is accepted and premium is realized by Tata AIG General Insurance Company Limited).

Loan Account No.:

Application No.:

Producer Code:

Applicant's Information

(Please wherever applicable)

Proposer's Name _____
 Father's/Husband's Name _____
 Date of Birth Sex Marital Status Nationality _____
 Occupation Employed Self Employed Full Time Part Time Current Address is Self-Owned Rented Co. Leased
 Address for Communication _____
 District _____ City _____ Pin Code _____
 State _____ Tel (O) - _____
 Tel (H) - _____ Mobile _____ Email _____
 PAN No. _____ No. of Dependents _____ Children Others
 Education/Qualification _____ Employer / Business Name _____ Department _____
 Designation _____ Monthly Income _____ Other Income (if any) Rs. _____ Sources of funds _____
 Employer / Business Address _____
 Employer / Business Contact Number - _____ Years in Present Occupation _____
 Address of the Property to be covered _____
 _____ Pin Code _____
 Years of Construction Loan Amount _____ Loan Tenure _____ Policy Tenure _____
 *Sum Insured Fixed Contents Sum Insured _____ Premium Amount _____
 Would you like to cover household contents against the risk of Fire & Special Perils and Burglary & Theft. Yes No
 If Yes, Sum Insured _____
 Do you want to Co-Applicant to be part of Home Guard Plus Policy? Yes No

Co-Applicant's Information

Co-Applicant's Name _____
 Father's/Husband's Name _____ Relationship with Applicant _____
 Date of Birth Sex Marital Status Nationality _____
 Occupation Employed Self Employed Full Time Part Time Current Address is Self-Owned Rented Co. Leased
 Address for Communication _____
 District _____ City _____ Pin Code _____
 State _____ Tel (O) - _____
 Tel (H) - _____ Mobile _____ Email _____
 PAN No. _____ No. of Dependents _____ Children Others
 Education/Qualification _____ Employer / Business Name _____ Department _____
 Designation _____ Monthly Income _____ Other Income (if any) Rs. _____ Sources of funds _____
 Employer / Business Address _____
 Employer / Business Contact Number - _____ Years in Present Occupation _____
 Address of the Property to be covered _____
 _____ Pin Code _____
 Years of Construction Loan Amount _____ Loan Tenure _____ Policy Tenure _____
 *Sum Insured Fixed Contents Sum Insured _____ Premium Amount _____
 Would you like to cover household contents against the risk of Fire & Special Perils and Burglary & Theft. Yes No
 If Yes, Sum Insured _____

* The amount % of sum insured will be in proportion of the contribution to Home loan payment

Home Guard Plus Policy

Nominee*

* Nominee for self has to be one of the below mentioned relations.

Father Mother Son Daughter Spouse Others

If Nominee is "Others" please specify: _____

Applicant	Nominee*	Name of Nominee	DOB	Age	% of Sum Insured
Nominee 1			D D M M Y Y Y Y		
Nominee 2			D D M M Y Y Y Y		
Nominee 3			D D M M Y Y Y Y		
Nominee 4			D D M M Y Y Y Y		

Co-Applicant	Nominee*	Name of Nominee	DOB	Age	% of Sum Insured
Nominee 1			D D M M Y Y Y Y		
Nominee 2			D D M M Y Y Y Y		
Nominee 3			D D M M Y Y Y Y		
Nominee 4			D D M M Y Y Y Y		

Fire and Burglary Cover Information:

1. Fire Extinguishing System:

- a. Hand Appliances Y N (If Yes, details thereof) _____
- b. Hydrant Y N (If Yes, details thereof) _____
- c. Smoke, Fire Alarm Y N (If Yes, details thereof) _____
2. Security Guard Y N
3. Burglar Alarm Y N (If Yes, details thereof) _____
4. Property is in good state of repair Y N
5. Occupancy Occupied Unoccupied
6. Claim History _____
7. Flood History _____
8. Distance from sea, river, lake etc. _____
9. Is it in a low lying area? Y N

Medical Information

1. Have you suffered / are suffering from any disease / illness? Yes No
If yes, indicate in the table below.

S.No.	Name	Name of Disease Suffering from	When First treated	Name of attending medical practitioner with address and telephone no.	Is it fully cured?
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N

2. Do you have other current or pending critical illness Insurance with Tata AIG General Insurance Company Limited or from any other Insurance Company/
If yes Policy No.: _____ Sum Insured: _____ Insurance Company Name: _____

3. Information for Critical Illness Cover

Please tick Yes/No

	Applicant	Co-Applicant
1. Has your Health Insurance/Life Insurance proposal ever been declined?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Are you now in good health & entirely free from any mental/physical impairments or deformities?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Height (in cm) & Weight (in kg.) details	Ht. [] [] [] Wt. [] [] []	Ht. [] [] [] Wt. [] [] []
4. Have you lost more than 5 kgs weight in last 3 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever suffered from or do you suffer from Diseases of the circulatory system? E.g. Heart Disease, Chest pain, High blood pressure, Diseases of Arteries/Veins	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you ever suffered from or do you suffer from Diabetes Mellitus, Cancer or Tumor of any kind, or any diseases of Blood Glands, Spleen, Ears, Eyes, or Skin?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Have you ever suffered from or do you suffer from diseases of the Respiratory system (Lung Diseases) e.g., Tuberculosis, Asthma, Emphysema, Pneumonia?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Do you have/had any complaints of difficulty in Breathing, Blood in Sputum or Persistent Respiratory Infections?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Have you ever suffered from or do you suffer from any disease of Genitourinary System/Kidneys?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. Do you have/had any complaints of swelling over face/Lower limbs?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
11. Have you ever suffered from or do you suffer from diseases of the Nervous system or Mental Disorders e.g. Stroke, Epilepsy, Fits/Fainting attacks, Frequent Headache, Psychiatric Disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
12. Do you have/had any complaints of Weakness in Limbs, tingling numbness, loss of Power in limbs or any other similar complaints?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

In case of more than one co-applicants are applicable then please fill up separate Medical Information Sheets for each co-applicant & attach along with the proposal form

	Please tick Yes/No		Applicant		Co-Applicant	
	YES	NO	YES	NO	YES	NO
13. Have you at any time suffered from recurrent episodes of Hepatitis/Blood in Vomiting or Stool, recurrent Diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. a. Have you or any of your immediate family members (Father/Mother/Brother or Sister) have/had Cancer, Heart Attack, and Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Was it prior to 60 yrs of age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever taken Narcotics/other habit forming Drugs or being treated for the same?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you been treated for Alcoholism related Diseases?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you smoke more than 20 cigarettes/day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you suffered from any other Diseases or Ailments not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you taken treatment/done investigations, for e.g. (CT scan, X rays etc) for any ailment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the answer is "Yes" for any of the above please provide details in the space given below.

Family Doctor's Details: Name _____ Contact Nos. _____
 Clinic/Hospital/Nursing Home No. _____
 Policy period From _____ To _____

Declaration & Warranty on behalf of All Persons Proposed to be Insured:

- I/We 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/We am/are authorized to propose on behalf of these other persons.
- I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved underwriting policy of the Insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- I/We further declare that I/We 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/We declare and consent to the company seeking medical information from any hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory Authority.

Applicant Name: _____ Signature: _____

Declaration
 The content of this form along with product benefits, terms/conditions and exclusions have been clearly explained to me. I/we have understood these and confirm to abide by the policy terms & conditions.

Signature of the Proposer: _____

Name & Signature of agent/intermediary: _____

Code: _____

Vernacular Declaration (Certification in case the proposer has signed in vernacular/thumb print):
 The content of this form along with product benefits, terms/conditions and exclusions have been clearly explained by me in vernacular to the proposer who has understood and confirmed the same.

Signature/Thumb impression of the Proposer: _____

Name & Signature of agent/intermediary: _____

Agent Declaration:
 I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favor pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

License No. (Intermediary/Corporate Agent/Broker/Relationship Officer)

Name of the specified Person and code

Place: _____

Date: Signature of Agent: _____

Prohibition of Rebates - Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.
 1. 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 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 published prospectus or tables of the insurer.
 2. Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to ten lakh rupees.

Grievance Redressal Procedure: As per Regulation 17 of IRDA of India (Protection of Policy holders Interests) Regulation. 2017.
Section 64 VB of the Insurance Act 1938: Commencement of risk cover under the policy is subject to receipt of premium by Tata AIG General Insurance Company Limited.



Tear Away

AML Guidelines and Terms & Conditions

AML Guidelines

1. I/we hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in prevention of Money Laundering Act, 2002.
2. I understand that the Company has the right to call for documents to establish sources of funds.
3. The insurance company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

• Nationality Indian Non-Indian

If Non-Indian, please specify Country: _____

• Type of Organization

Corporations Governments Non Governmental Organizations Society International Organization
Trust Partnership Cooperatives Section 25 Company

Premium Payment Details

Amount Rs.

Cheque / DD No. Date: Bank & Branch _____

Sources of funds: Salary Business Other _____

(Insured's PAN Card No.: (In the absence of PAN Card, please give details of any other authorized photo identification card.)

Photo ID Type _____ Photo ID No.:

Letter Of Administration

The Manager

Bank Name: _____

Bank Address: _____

Date: _____

Dear Sir,

Ref: Letter of administration for Home Guard Plus Policy

Loan Account No. _____

I would like to appoint _____ as my administrator to Home Guard Plus Policy offered by Tata AIG General Insurance Company Limited (Tata AIG)

I authorize _____ to collect and remit my premiums to Tata AIG. I also authorize _____ to use and disclose any information collected or held (contained in my application forms or otherwise obtained) to enable the company / its associated individuals / organization or independent third parties, within or outside the country, to provide advice or information concerning products or services that the company believes may be of interest to me or to communicate with me for any purpose.

I understand that the Home Guard Plus Policy has been underwritten by Tata AIG and that all the claims will be settled by Tata AIG.

I hereby agree to _____ conveying all the above particular in my application forms to Tata AIG to enable them to issue the Home Guard Plus Policy to me/us.

Signature of the Account Holder _____ Name: _____

Statutory Disclaimer:

Insurance is the subject matter of the solicitation. For more details on risk factors and terms and conditions, please read the sales brochure carefully before concluding a sale. The benefits and features of the products and services are purely indicative in nature.

Home Guard Plus Policy

Tata AIG General Insurance Company Limited

Registered Office: Peninsula Business Park, Tower A, 15th Floor, G.K. Marg, Lower Parel, Mumbai - 400 013
24x7 Toll Free No: 1800 266 7780 Fax: 022 6693 8170 Email: customersupport@tataaig.com Website: www.tataaig.com
IRDAI Registration No: 108 CIN: U85110MH2000PLC128425

Auto Debit Instruction for Premium Payment:

I, the undersigned having a _____ saving Account No. _____ (Referred to as account) do hereby unconditionally and irrevocably authorize _____ to debit my account for Rs. _____ towards the Home Guard Plus Policy Insurance Premium as indicated above. I agree that my bank account will be debited for the amount mention above and money would be transferred to Tata AIG General Insurance Company Ltd. (Tata AIG) for commencing the risk under the policy. I understand and agree that risk under the policy would not commence, if account couldn't be debited for any reasons, whatsoever and I will have no claim against _____ or Tata AIG for loss of any nature suffered by me.

Acknowledgment Slip

Proposal form received from: Mr./Mrs./Ms. _____

Address: _____

Premium Amount: Rs. _____

Bank Name: _____

Or Cheque No.: _____ Date _____ Branch _____

Sum Insured Opted: _____ Tenure _____