

Proposal Form – TATA AIG Hope

URN No.: AH/2023-24/HL-14

Proposal no. _____ Intermediary Code: _____

This is an application for insurance and issuance of this does not amount to acceptance of proposal by us. Commencement of risk under this proposal is subject to acceptance of the risk by us and receipt of premium.

The information declared by you in this form is the basis for issuance of the policy. Please answer all questions carefully. Any incomplete, incorrect or partially correct answers may lead to rejection of the proposal and also might lead to cancelation of policy.

“I hereby declare that I have read and understood and following conditions which are pre-requisite to apply for TATA AIG Hope. I confirm to abide by the same.

- a. Age eligibility of Proposer:
 - Surrogacy Plan – (i) Intending Couple: Male member – 26 to 55 Years, Female member – 23 to 50 Years, (ii) Intending Woman – 35 to 45 Years
 - Oocyte Retrieval Plan - (i) Intending Couple: Male member – 21 to 55 Years, Female member – 21 to 50 Years, (ii) Intending Woman – 35 to 45 Years
- b. Mandatory requirement for the intending couple (For Surrogacy Plan):
 - Certificate of recommendation from the Board when an intending couple has a medical indication necessitating gestational surrogacy.
- c. The proposal for insurance has to be made before the embryo transfer for the Surrogate Mother and/or before ovarian stimulation for Oocyte Donor.
- d. Surrogacy and Oocyte donation is carried out in recognized centers registered with the National ART and Surrogacy Registry at <https://registry.artsurrogacy.gov.in/>, under the supervision of registered Medical Practitioner as per the applicable law.
- e. The Surrogacy/ART procedures and treatments is carried out in accordance with the Surrogacy (Regulation) Act, 2021, Surrogacy (Regulation) Rules, 2022, Assisted Reproductive Technology Act, 2021, Assisted Reproductive Technology (Rules), 2022 and its amendments as may be applicable.”

Please fill-up this form in CAPITAL LETTERS

1. PROPOSER'S DETAILS

(Mr /Mrs /Ms /Dr)	First Name	Middle Name	Surname
Date of Birth (dd/mm/yyyy)		Gender	Male / Female/ Others
Mobile		Unique Govt ID No.	

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Tata AIG General Insurance Company Limited

Annual Income (in ₹ lakhs)	Upto 3 / 3 to 6 / 6 to 10 / 10-15/ 15-20/ 20-25/ >25		
E-Mail ID			
Address			
Landmark		Area	
City/Town		Pin Code	
District		State	
Nationality	<input type="checkbox"/> Indian <input type="checkbox"/> Foreign Nationals		
Embryo Transfer Date/Oocyte Donation Date (Proposal date should be before this date)	DD/MM/YYYY		
Do you have the Surrogacy eligibility Certificate?	Y/N, If Yes then Date of Issue of the Certificate		

Tata Group Employee

Tata Group Employee ID _____

2. POLICY DETAILS

Proposed Policy Commencement Date:

d	d	m	m	y	y	y	y

Surrogacy Plan

Oocyte Retrieval Plan

3. DETAILS OF THE PERSON(S) TO BE INSURED

Sr. No.	Name of the Insured Person	Gender	Relationship with Proposer*	Date of Birth	Height	Weight	Sum Insured (₹)#
1.		F		dd/mm/yyyy	(cms)	(Kgs)	

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* Allowed relations (Self, Surrogate Mother, Oocyte Donor)

Sum Insured options available - ₹2, 3, 5 Lakhs

4. NOMINEE DETAILS

In the event of the death of the Proposer any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions.

Nominee Name	Date of Birth*	Relationship	Address of the Nominee

*If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship	Address of the Appointee

5. EXISTING/PREVIOUS INSURER DETAILS

Is the proposer or any of the person proposed, already Insured under a health plan with Tata AIG General Insurance Company Ltd. or any other insurer or is a proposal pending for Policy issuance? If yes, please indicate the Policy/ Application number(s): _____

Since when continuously insured: DD/MM/YYYY

Policy No.	Name of Insured Person	Insurer	Period of Insurance		Sum Insured & Cumulative Bonus (₹)	Claims lodged during the preceding years along with the diagnosis
			From	To		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		
			DD/MM/YYYY	DD/MM/YYYY		

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6. MEDICAL AND LIFESTYLE DETAILS

A. Medical History:

Please answer the below mentioned questions individually in Yes(Y)/No (N): You must answer the questions truthfully. Not doing so would lead to termination of your policy.

Please answer each of the following questions individually for each Insured Person by ticking the relevant box.	Insured Person
	1
Have you ever suffered from or taken treatment, or hospitalized for or have been recommended to take investigations / medication / surgery or undergone a surgery for the following medical conditions?	
<input type="checkbox"/> Chest Pain / Heart Disease/Insulin Dependent Diabetes	Y/ N
<input type="checkbox"/> Arthritis	Y/ N
<input type="checkbox"/> COPD	Y/ N
<input type="checkbox"/> Kidney Failure, Dialysis	Y/ N
<input type="checkbox"/> Liver Cirrhosis/Hepatitis B or C	Y/ N
<input type="checkbox"/> Cancer	Y/ N
<input type="checkbox"/> HIV/AIDs	Y/ N
<input type="checkbox"/> Stroke, Epilepsy, Paralysis	Y/ N
<input type="checkbox"/> Psychiatric, Mental Illness or disorder	Y/ N
<input type="checkbox"/> Ulcerative Colitis/Crohn's disease	Y/ N
<input type="checkbox"/> Auto-immune diseases	Y/ N
<input type="checkbox"/> STDs	Y/ N
Any other illness/disease/injury/disability in the past other than for childbirth, flu or for minor injuries that have completely healed?	Y/ N
Are you on regular medication (including any Ayurvedic treatment) or Hospitalized for any illness/ surgery or awaiting any procedure/treatment?	Y/ N
Do you have any signs, symptoms, illness or injury including knee joint ligament tear or back pain/ Swelling or Pain in any part of body / Breathlessness on mild effort / dizziness more than once in last 6 months for which medical consultation / treatment / investigation has been required?	Y/ N
Have you ever been diagnosed with any of these medical conditions with or without any follow-up tests/medications? – Elevated Blood Sugar/ Type 2 Diabetes Mellitus / Elevated Blood Pressure/ Hypertension/High Cholesterol/ Asthma	Y/ N
Have you ever been diagnosed with any Thyroid Disorder with or without any follow-up tests/medications?	Y/ N
Is any of the insured pregnant currently? If yes, please mention expected date of delivery (EDD). Any history of pregnancy related complications?	Y/ N
EDD: DD/MM/YYYY	

Has any application for life, Health or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?	Y/ N
Has any health or life insurance policy ever been terminated in the past?	Y/ N
Have you undergone any annual health check-up or routine medical examination in the past year? (If yes, please provide details of any findings or results)	Y/ N
Have you been suffering/suffered from pregnancy related complications?	Y/N
Have you been diagnosed with any gynaecological disease for which any intervention, hormonal replacement therapy or medication exceeding 5 days have been prescribed	Y/N
Any history of Oocyte Donation	Y/N
Any history of Surrogacy	Y/N

B. Detailed information in case any of the questions in section 6 (A) is ticked 'Yes'.

(Please send us medical documents along with this application form.)

Insured Name	Name of Disease(surgical)	Operative status	Type of surgery	Treatment status	Complication(s)

Insured Name	Name of Disease(medical)	Date of diagnosis	Medication history	Mode of medication	Progress	Complication(s)

Insured Name	Remarks

C. Lifestyle Information

Does any person proposed to be insured smoke or consume Gutka/Pan Masala or Alcohol? Yes/No

If yes please indicate the name and quantity per day.

	Insured Person 1
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Alcohol (in ml)	Quantity + Frequency +Duration
<ul style="list-style-type: none"> • Per day • Per week • Per month • Occasionally 	
Smoking (No of Cigarettes or Bidis)	Quantity + Frequency+Duration
<ul style="list-style-type: none"> • Per day • Per week • Per month • Occasionally 	
Pan Masala/Tobacco (in gms)	Quantity + Frequency+Duration
<ul style="list-style-type: none"> • Per day • Per week • Per month • Occasionally 	
Other habit forming substances/addictive (Quantity consumed)	
<ul style="list-style-type: none"> • Per day • Per week • Per month • Occasionally 	

7. PAYMENT DETAILS

Name of the Premium Payer: (if different from proposer)

Relationship with the proposer: (if different from proposer)

Premium Amount (in ₹)

Instrument type: Cheque Debit Card Credit Card Others

Please make a Crossed Cheque/DD/Pay Order in favour of 'Tata AIG General Insurance Company Limited' only.

Sources of funds: Salary Business Other _____

AML guidelines:

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Tata AIG General Insurance Company Limited

1. I/we hereby confirm that all premiums paid / payable in future will be from bonafide sources and not paid out of proceeds of crime and that such premiums are not disproportionate to my/our income. I / we understand that the Company has the right to call for documents to establish sources of funds and to cancel the insurance policy in case I / we are found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering law in India.
2. I / we are not Politically Exposed Persons ** nor are their close relatives /family members/associates. I / we shall keep the company informed if we subsequently become a Politically Exposed Person / close relative / family member / associate of Politically Exposed Persons.

**“Politically Exposed Persons” shall have the meaning assigned to it under Prevention of Money-Laundering (Maintenance of Records) Amendment Rules, 2023 as amended from time to time.

Type of Organization making the payment (Pls tick)

- Limited company
- Government organization
- Non-Governmental Organization (NGO)
- Society
- Trust
- Partnership
- International Organization
- Cooperatives
- Section 25 Company

Signature of Proposer & Date :

8. BANK DETAILS (REQUIRED FOR REFUND/CLAIMS)

As per Regulatory requirements, we can effect payment of refund / claims only through Electronic Clearing System (ECS) / National Electronics Funds Transfer (NEFT) / Real Time Gross Settlement (RTGS) / Interbank Mobile Payment Service (IMPS)

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For this purpose, please submit the following details of the proposer’s bank account.

Name of the account holder	
Name of the bank	
Branch Bank	
Account no.	
Bank IFSC code	
Account Type	<input type="checkbox"/> SB Account <input type="checkbox"/> Current Account <input type="checkbox"/> Others (please specify)

9. DECLARATION & WARRANTY ON BEHALF OF THE PERSON PROPOSED TO BE INSURED

- I hereby declare, on my behalf and on behalf of the person 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 this other person.
- 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.
- 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.

□□□□□□□□
DDMMYYYY

Signature of the Proposer: _____

- GoGreen: I would like to protect my environment and would like to help save paper by authorizing Tata AIG General Insurance Company Limited to send all my policy and service

12. 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 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.

13. FOR OFFICE USE ONLY

Tata AIG Office Code: _____ Intermediary Code and Name: _____
Branch Receipt Date: _____ Channel Type: _____
Business Type: Urban/ Rural/ Social _____ Customer ID - _____

Tata AIG General Insurance Company Limited.

Insurance is the subject matter of the solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale.

Tata AIG General Insurance Company Limited. Registered Office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Off Senapati Bapat Road, Lower Parel, Mumbai- 400013, Maharashtra, India.

24X7 Toll Free No: 1800 266 7780 or 1800 22 9966 (For Senior Citizens)

Email:customersupport@tataaig.com Website: www.tataaig.com IRDA of India Registration No: 108
CIN: U85110MH2000PLC128425

14. ACKNOWLEDGEMENT (TO BE GIVEN TO CUSTOMER)

Proposal Number: _____ Date: _____
Name _____ of _____ the _____ Proposer

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We acknowledge with thanks the receipt of your proposal for TATA AIG Hope and amount by cheque/Demand Draft/others _____ of amount of ₹_____. Neither the submission to us of a completed proposal for insurance nor any payment towards this application 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 proposal is not accepted by us or you do not accept the terms of counter offer or premium is not received by us in full and in time, or non-fulfillments of Pre-Policy Checkup and/or additional information requested by us. We shall have no liability to make any payment under the Policy if proposal is under-process & claim arises in the interim period before the decision on the proposal is given by us. In case of counter offer you need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 15 days, we shall cancel application and refund the amount paid against this proposal without interest subject to deduction of the Pre Policy Check up charges, as applicable. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 10 days subject to deduction of the Pre-Policy Check up charges, as applicable.

