TATA AIG
CRITI MediCare

TATA AIG INSURANCE
WITH YOU ALWAYS

PROPOSAL FORM

Proposal No. _____ Client ID: _____

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.

Please fill-up this form in CAPITAL LETTERS

1. PROPOSER'S DETAILS

Name (Mr/Mrs/Ms/Dr): First Name | Middle Name | Surname

Marital Status: ☐ Married ☐ Single ☐ Others Gender : ☐ Male ☐ Female

Date of Birth: D D M M Y Y Y Y Occupation: ☐ Pvt Service ☐ Govt Service ☐ Business

Nationality:

Address:

Landmark:

City/Town: District:

Pin Code: State:

Mobile: Telephone/ Alternate No:

E-Mail:

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 related communication to the email id as mentioned in this application form. For detailed terms, conditions, exclusions and policy wordings please refer our website (www.tataaig.com)

☐ Tata Group Employee

Annual Income (in Lakhs ₹): ☐ up to 3 ☐ 3-6 ☐ 6-10 ☐ 10-15 ☐ 15-20 ☐ 20-25 ☐ more than 25

Govt ID Proof:

ID No.:

PAN Card:

(Mandatory in case of premium >Rs.1 Lakh)

2. PLAN DETAILS

Proposed Policy Period: From D D M M Y Y Y Y to D D M M Y Y Y Y

Policy Tenure: ☐ 1 Year ☐ 2 Years (5% premium discount) ☐ 3 Years (10% premium discount)

Please select atleast one base cover. All proposed members will have same plan.

Base Cover	☐ Section A (Critical Illness) *Please select plan* ☐ Smart Century Premier ☐ Smart Half Century
	Please select survival period ☐ 0 Day ☐ 7 Days ☐ 15 Days

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Base Cover	☐ Section B (Cancer 360 degree Indemnity Cover)	
	☐ Section C (Hospital Cash)	☐ 30 Days ☐ 60 Days ☐ 180 Days
Optional Benefit	☐ Wellsurance Benefit	☐ Classic ☐ Supreme ☐ Elite

Please note: Sum Insured is on Individual Basis.

Policy Plan Option	Section A (Critical Illness)	Section B (Cancer 360 degree Indemnity Cover)	Section C (Hospital Cash)
Insured Person	*Sum Insured (in Rs):* 5 Lakhs to 2 Cr (in multiples of 5 Lakhs)	*Sum Insured(In Rs):* 5 Lakhs to 2 Cr in multiples of 5 Lakhs	*Sum Insured (in Rs): 500 to Rs. 20,000 (in multiples of 500's) per day for 30/60/180 days*
1			
2			
3			
4			
5			
6			
7			

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

Sr. No	Name of the Insured Person	Height	Weight	Relationship with Proposer	Gender	Date of Birth
1		(cms)	(Kgs)		M / F	dd/mm/yyyy
2		(cms)	(Kgs)		M / F	dd/mm/yyyy
3		(cms)	(Kgs)		M / F	dd/mm/yyyy
4		(cms)	(Kgs)		M / F	dd/mm/yyyy
5		(cms)	(Kgs)		M / F	dd/mm/yyyy
6		(cms)	(Kgs)		M / F	dd/mm/yyyy
7		(cms)	(Kgs)		M / F	dd/mm/yyyy

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.

Sr. No	Insured Person	Nominee Name	Date of Birth*	Relationship
1			dd/mm/yyyy	
2			dd/mm/yyyy	
3			dd/mm/yyyy	
4			dd/mm/yyyy	
5			dd/mm/yyyy	
6			dd/mm/yyyy	
7			dd/mm/yyyy	

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

Appointee Name	Relationship

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5. EXISTING/PREVIOUS INSURER DETAILS

Is the proposer or any of the persons 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: D D M M Y Y Y Y

Do you want Us to consider these details for portability* Yes ☐ No ☐

**In case of portability, please fill up IRDAI portability form. Please note that continuity of benefits shall NOT be considered if the details are not provided. You need to approach at least 45 days prior to your expiry date to avoid any break in coverage. Please submit previous 4 years insurance policy copies. Portability is subject to IRDAI portability guidelines.*

Policy No.	Name of Insured person	Insurer	Period of Insurance		Sum Insured & Cumulative bonus / (Rs)	Deductible (Rs.)	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			

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	2	3	4	5	6	7
Have you or any of the persons proposed for insurance, 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?							
☐ Chest Pain / Heart Disease	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Arthritis	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ COPD	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Kidney Failure, Dialysis	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Liver Cirhosis/Hepatitis B/C	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Cancer	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ HIV/AIDs	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Stroke, Epilepsy, Paralysis,	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Psychiatric, Mental Illness or disorder	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Ulcerative Colitis/Crohn's disease	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Auto-immune diseases	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ STDs	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	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	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Are you or any persons proposed on regular medication (including any Ayurvedic treatment) or awaiting any procedure/treatment?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Have you ever been diagnosed with any of these medical conditions with or without any follow-up tests/medications?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Elevated Blood Sugar	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Diabetes	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Elevated Blood Pressure/ Hypertension	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ High Cholesterol	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
☐ Hypothyroidism	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Is any of the insured pregnant currently? If yes, please mention expected date of delivery (EDD). Any history of pregnancy related complications? EDD: D D M M Y Y Y Y	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

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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	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Has any health or life insurance policy ever been terminated in the past?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

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

(Please send us medical documents along with this proposal form)

Name and details of Illness (for questions answered as Yes in Section A & B above)	Diagnosis as per documents	Diagnosis date	Date of last consultation	Treatment details	Name of Surgery or procedure/ Medicines	Doctor/Hospital Name and Phone No.
Insured Person 1						
Insured Person 2						
Insured Person 3						

C. Lifestyle Information

Does any person proposed to be insured smoke or consume gutka/pan masala or alcohol. If yes please indicate the name and quantity per day.	Insured Person						
	1	2	3	4	5	6	7
Alcohol (ml) Per day ☐ Per week ☐ Per month ☐ Occasionally ☐							
Smoke (No. Cigarette/Bidis) Per day ☐ Per week ☐ Per month ☐ Occasionally ☐							
Pan Masala/Tobacco (Grams) Per day ☐ Per week ☐ Per month ☐ Occasionally ☐							
Others habit forming substances/addictives 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 Rs): ☐☐☐☐☐☐☐☐

Direct Debit Authorization

Instrument type: ☐ Cash ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Others

Sources of funds: ☐ Salary ☐ Business ☐ Other ____________________

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

☐ I/We authorize Bank, to debit my account through ECS (Debit) clearing / Direct debit (Standing instruction) for Auto Renewal of the policy.

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

Type of Organization

- ☐ Corporations
- ☐ Governments
- ☐ Non Governmental Organizations
- ☐ 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 (RGTS) / Interbank Mobile Payment Service (IMPS)
For this purpose please submit the following details of the insured's bank account.*

Name of the Account Holder	
Name of the Bank	
Branch Bank	
Account No.	
Bank IFSC Code	
Account Type	☐ SB Account ☐ Current Account ☐ Others (please specify)

If the premium cheque is not paid from the above mentioned account then a cancelled cheque leaf of the above mentioned Account is to be attached.

#mandatory if annualized premium is more than Rs 10,000

9. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- ☐ 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 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.
- ☐ I have understood the purpose of Aadhar authentication and hereby state that I have no objection in providing my Aadhar details.

Date: D D M M Y Y Y Y Signature of Proposer: _____

10. DECLARATION/VERNACULAR 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: _____

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: _____

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11. 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: _____

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

Branch Receipt Date: _____ Intermediary Code and Name: _____

Branch Receipt Date: _____ Channel Type: _____

Business type: ☐ Urban ☐ Rural ☐ Social Customer ID:_____

Tata AIG Office Code:_____

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.
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TATA AIG
CRITI
MediCare

TATA AIG INSURANCE
WITH YOU ALWAYS

ACKNOWLEDGEMENT (TO BE GIVEN TO CUSTOMER)

Proposal Number: _____ Date: _____

Name of the Proposer _____

We acknowledge with thanks the receipt of your application for Tata AIG Criti-MediCare and amount by

☐ Cash ☐ Cheque ☐ Demand Draft ☐ Others _____ of amount of Rs. ☐☐☐☐☐☐☐☐

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 premium paid 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.

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