

URN No.: AH/2020-21/HL-17

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

[illegible]

Marital Status: ☐ Married ☐ Single ☐ Others

Gender : ☐ Male ☐ Female

Date of Birth: 

D	D	M	M	Y	Y	Y	Y
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Occupation: ☐ Pvt Service ☐ Govt Service ☐ Business

[illegible]

Address:

Landmark:

City/Town: \_\_\_\_\_ District: \_\_\_\_\_

Pin Code:

Mobile:											Telephone/ Alternate No:								
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E-Mail:	
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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](http://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.:	
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[illegible]

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

## 2. PLAN DETAILS

Proposed Policy Period: From 

D	D	M	M	Y	Y	Y	Y
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 to 

D	D	M	M	Y	Y	Y	Y
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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	<input type="checkbox"/> Section A (Critical Illness) <i>Please select plan</i> <input type="checkbox"/> Smart Century Premier <input type="checkbox"/> Smart Half Century
	<i>Please select survival period</i> <input type="checkbox"/> 0 Day <input type="checkbox"/> 7 Days <input type="checkbox"/> 15 Days

Base Cover	<input type="checkbox"/> Section B (Cancer 360 degree Indemnity Cover)	
	<input type="checkbox"/> Section C (Hospital Cash)	<input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 180 Days
Optional Benefit	<input type="checkbox"/> Wellsurance Benefit	<input type="checkbox"/> Classic <input type="checkbox"/> Supreme <input type="checkbox"/> 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

## 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):

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Since when continuously insured:

D	D	M	M	Y	Y	Y	Y
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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?															
<input type="checkbox"/> Chest Pain / Heart Disease	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> Arthritis	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> COPD	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> Kidney Failure, Dialysis	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> Liver Cirrhosis/Hepatitis B/C	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> Cancer	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> HIV/AIDs	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> Stroke, Epilepsy, Paralysis,	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> Psychiatric, Mental Illness or disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> Ulcerative Colitis/Crohn's disease	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> Auto-immune diseases	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> 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								
<input type="checkbox"/> Elevated Blood Sugar	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> Diabetes	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> Elevated Blood Pressure/ Hypertension	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> High Cholesterol	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
<input type="checkbox"/> 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?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
EDD: <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y							
D	D	M	M	Y	Y	Y	Y								

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 <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Occasionally <input type="checkbox"/>							
Smoke (No. Cigarette/Bidis) Per day <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Occasionally <input type="checkbox"/>							
Pan Masala/Tobacco (Grams) Per day <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Occasionally <input type="checkbox"/>							
Others habit forming substances/addictives Per day <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Occasionally <input type="checkbox"/>							

**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 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

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Corporations               | <input type="checkbox"/> Governments  | <input type="checkbox"/> Non Governmental Organizations |
| <input type="checkbox"/> Society                    | <input type="checkbox"/> Trust        | <input type="checkbox"/> Partnership                    |
| <input type="checkbox"/> International Organization | <input type="checkbox"/> Cooperatives | <input type="checkbox"/> 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	<input type="checkbox"/> SB Account <input type="checkbox"/> Current Account <input type="checkbox"/> 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
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Signature of Proposer: \_\_\_\_\_

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.

Name & Signature of agent/intermediary: \_\_\_\_\_

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.

Name & Signature of agent/intermediary: \_\_\_\_\_

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.

[illegible][illegible]

Place: \_\_\_\_\_ Date: \_\_\_\_\_ Signature of Agent: \_\_\_\_\_

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.

Tata AIG Office Code: \_\_\_\_\_

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.

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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. 

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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.

Tata AIG General Insurance Company Limited

Regd Office: 15th Floor, Tower A, Peninsula Business Park, G. K. Marg, Lower Parel, Mumbai - 400 013, Maharashtra, India.  
24x7 Toll Free No: 1800 266 7780 OR 1800 229966 (For Senior Citizens) | Email: customersupport@tataaig.com  
IRDA of India Registration No.: 108 • Website: www.tataaig.com | URN No: AH/2020-21/HL-17  
CIN: U85110MH2000PLC128425 | UIN: TATHLIP22176V012122