

PROPOSAL FORM

POS PAN No. ((Mandatory for POS Agent): _____ Intermediary Name : _____

Intermediary Code: _____ Proposal no: _____

This is an application for insurance and does not amount to acceptance of coverage by us. Commencement of risk under this proposal is subject to we accepting it and receipt of full 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 cancellation 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: Occupation: Pvt Service ☐ Govt Service ☐ Business ☐

Mobile:

PAN Card: OR Voter's ID

E-Mail:

Monthly income

Address:

Landmark

Area

City/Town District

Pin Code State

2. OTHER DETAILS

Plan type: Floater ☐ Individual ☐

Sum Insured: Rs. _____ 50,000 to 10,00,000 (in multiples of Rs. 50,000)

Premium payment mode: _____ (Yearly / Half yearly /Quarterly /Monthly)

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

SI No.	Name of the Insured Person	Gender	Relationship with Proposer*	Date of Birth	Unique ID	Height	Weight	Sum Insured#
1		M / F		DD/MM/YYYY		(cms)	(kgs)	
2		M / F		DD/MM/YYYY		(cms)	(kgs)	
3		M / F		DD/MM/YYYY		(cms)	(kgs)	
4		M / F		DD/MM/YYYY		(cms)	(kgs)	
5		M / F		DD/MM/YYYY		(cms)	(kgs)	
6		M / F		DD/MM/YYYY		(cms)	(kgs)	
7		M / F		DD/MM/YYYY		(cms)	(kgs)	
8		M / F		DD/MM/YYYY		(cms)	(kgs)	

* Allowed relations (Spouse, children and Parent and Parent in law)

Same Sum Insured for all members in floater option

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. The nominee must be an immediate relative of the Proposer. The nominee for all other Insured Persons proposed to be insured shall be the Proposer himself/ herself.

Nominee Name	Date of birth*	Relationship

*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):

D	D	M	M	Y	Y	Y	Y
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Since when continuously insured:

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 all previous year insurance policy copies.

Policy No.	Name of Insured person	Insurer	Period of Insurance		SI & Cumulative bonus / 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		
			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	8
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	Y / N
<input type="checkbox"/> Arthritis	Y / N	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	Y / N
<input type="checkbox"/> Kidney Failure, Dialysis	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
<input type="checkbox"/> Liver Cirrhosis/Hepatitis B or C	Y / N	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	Y / N
<input type="checkbox"/> Stroke, Epilepsy, Paralysis	Y / N	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	Y / N
<input type="checkbox"/> Auto-immune diseases	Y / N	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	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	Y/N								
Have you ever been diagnosed with any of these medical conditions with or without any follow-up tests/medications? – <input type="checkbox"/> Elevated Blood Sugar / <input type="checkbox"/> Diabetes / <input type="checkbox"/> Elevated Blood Pressure / <input type="checkbox"/> Hypertension / <input type="checkbox"/> High Cholesterol / <input type="checkbox"/> Hypothyroidism	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N								
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	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	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	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									

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	Diagnosis as per documents	Treatment details	Diagnosis date/ Surgery Date	Date of last consultation	Doctor/Hospital Name and Ph No.

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.	Insured Person							
	1	2	3	4	5	6	7	8
Alcohol (equivalent of 30ml Pegs of hard liquor/ bottles of beer/wine) • Per day • Per week • Per month • Occasionally								
Smoking (No of Cigarettes or Bidis) • Per day • Per week • Per month • Occasionally								
Pan Masala/Tobacco (no. of small -5gms-Packets) • Per day • Per week • Per month • Occasionally								
Others habit forming substances/addictive (Quantity consumed) • Per day • Per week • Per month • Occasionally								

URN No. : AH/2019-20/HL-14

7. PAYMENT DETAILS

Name of the Premium Payer: _____
if different from proposer

Relationship with the proposer: _____
if different from proposer

Premium Amount (Rs): _____

Instrument type: Cash ☐ 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:

- 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.
- 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.

Nationality : Indian ☐ Non-Indian ☐ If Non-Indian, please specify Country _____

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 (RGTS) / Interbank Mobile Payment Service (IMPS)
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	SB Account <input type="checkbox"/> Current Account <input type="checkbox"/> Others (please specify) <input type="checkbox"/>

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.

Signature of Proposer: _____ Date: _____

- ☐ **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 proposal form.

Proposal no:

Date :

ACKNOWLEDGEMENT

Name of the Proposer: _____

We acknowledge with thanks the receipt of your proposal for Arogya Sanjeevani Policy, Tata AIG General Insurance Company Ltd. 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 proposal obliges us to agree to issue a policy, this 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 30 days of the issuance of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 30 days, we shall cancel proposal 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.

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