

Proposal Form

URN No. AH/2024-25/HL-21

GUIDELINES FOR COMPLETION OF THE FORM

- This policy is specially designed for Persons with Disability and Persons with HIV/AIDS.
- Persons with Disability shall be covered if 40% disability is certified by the competent authority as per the Disability Act 2016.
- Only Indian Nationals can be covered under this policy.

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.

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.	
Annual Income in Rs	Upto 3 / 3 to 6 / 6 to 10 / 10-15/ 15-20/ 20-25/ >25 (in lakhs)		
E-Mail ID			
Address			
Landmark	Area		
City/Town	Pin Code		
District	State		
Permanent Address	<input type="checkbox"/> If same as Residential Address in India, please tick here		
Landmark	Area		
City/Town	Pin Code		

District		State											
PAN Card/Form 60/61		<table border="1" style="display:inline-table; border-collapse: collapse;"> <tr> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> </tr> </table>											

2. PLAN DETAILS

Proposed Policy Period

										T	O								
d	d	m	m	y	y	y	y					d	D	m	m	y	y	y	y

Policy Tenure: 1 Year

Sum insured type: Individual

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

Sr. No	Name of the Proposed Insured Person	Gender	Relationship with Proposer*	Date of Birth	Height	Weight	Sum Insured#	ABHA Number (14 digits)^
1.		M / F/Others		dd/mm/yyyy	(cms)	(Kgs)		

Options available (Rs.4 and 5 Lakhs)

^^Note: If ABHA Number is not available, we urge you to visit <https://abdm.gov.in/> for creation of ABHA ID and inform the same to us once created.

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.

Details/Particulars	Nominee 1	Nominee 2
Date of Birth*		
Relationship		
Present Address of the Nominee		
Permanent Address of the Nominee	<input type="checkbox"/> If same as Present Address, please tick here	<input type="checkbox"/> If same as Present Address, please tick here
Mobile		
Email ID		

Percentage Share for Claim Payable	Amount	
Bank Details of the Nominee		
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)	<input type="checkbox"/> SB Account <input type="checkbox"/> Current Account <input type="checkbox"/> Others (please specify)

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

Appointee Name	Relationship	Address of the Appointee

5. Previous/Existing Health Details of the Insured:

Do you suffer from HIV/AIDS?	Yes/No	If Yes, please enclose latest report with the current CD4 count (not older than 30 days)
Current CD 4 count	_____	
Has your CD4 Count dropped below 500 in the past 4 years?	Yes/ No. If yes, please mention the month and year of all such episodes	
Do you suffer from any disability as per the listed conditions mentioned below:	Yes/ No	If Yes, please tick against the relevant section in the below and enclose Disability certificate issued by competent authority (including percentage of disability)
1. Blindness <input type="checkbox"/>	2. Muscular Dystrophy <input type="checkbox"/>	
3. Low vision <input type="checkbox"/>	4. Chronic Neurological conditions <input type="checkbox"/>	
5. Leprosy Cured persons <input type="checkbox"/>	6. Specific Learning Disabilities <input type="checkbox"/>	
7. Hearing Impairment (deaf and hard of hearing) <input type="checkbox"/>	8. Multiple Sclerosis <input type="checkbox"/>	
9. Locomotor Disability <input type="checkbox"/>	10. Speech and Language disability <input type="checkbox"/>	
11. Dwarfism <input type="checkbox"/>	12. Thalassemia <input type="checkbox"/>	
13. Intellectual Disability <input type="checkbox"/>	14. Haemophilia <input type="checkbox"/>	
15. Mental Illness <input type="checkbox"/>	16. Sickle Cell disease <input type="checkbox"/>	
17. Autism spectrum disorders <input type="checkbox"/>	18. Multiple Disabilities including deaf/ blindness <input type="checkbox"/>	
19. Cerebral Palsy <input type="checkbox"/>	20. Acid Attack victim <input type="checkbox"/>	
21. Parkinson's disease <input type="checkbox"/>		

Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above?
Yes No

If Yes, please specify details and the no of years you are suffering: _____

6. EXISTING/PREVIOUS HEALTH 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?

Yes /No

If yes, please indicate the Policy/Application number(s) and Insurer name:

Policy No	Name of Proposed Insured Person	Insurer	Period of Insurance		Sum Insured & 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		

7. 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 proposed Insured Person by ticking the relevant box.	Proposed 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 or 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"/> Stroke, Epilepsy, Paralysis	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? – Elevated Blood Sugar/ Diabetes/ Elevated Blood Pressure/ Hypertension/High Cholesterol/ Hypothyroidism	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
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 6 (A) is ticked 'Yes'.

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

Proposed Insured Name	Name of Disease(surgical)	Operative status	Type of surgery	Treatment status	Complications(S)

Proposed Insured Name	Name of Disease(medical)	Date of diagnosis	Medication history	Mode of medication	Progress	Complications(S)

Proposed Insured Name	Remarks
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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.

	Proposed Insured Person	
	1	2
Alcohol (in ml) <ul style="list-style-type: none"> • Per day • Per week • Per month • Occasionally 	Quantity + Frequency +Duration	
Smoking (No of Cigarettes or Bidis) <ul style="list-style-type: none"> • Per day • Per week • Per month • Occasionally 	Quantity + Frequency+Duration	
Pan Masala/Tobacco (in gms) <ul style="list-style-type: none"> • Per day • Per week • Per month • Occasionally 	Quantity + Frequency+Duration	
Others habit forming substances/addictive (Quantity consumed) <ul style="list-style-type: none"> • Per day • Per week • Per month • Occasionally 		



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Model Policy for HIV/AIDS and Persons with Disability, TATA AIG GENERAL INSURANCE COMPANY LIMITED



8. PAYMENT DETAILS

Name of the Premium Payer: (if different from proposer)
 Relationship with the proposer: (if different from proposer)
 Premium Amount (in Rs.)
 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:

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 person(s).

**"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: India 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

TATA AIG GENERAL INSURANCE COMPANY LIMITED

Registered office: Peninsula Business Park, Tower A, 15th Floor, G.K Marg, Lower Parel, Mumbai - 400013, Maharashtra, India
 24*7 Toll free No.: 1800 266 7780/1800 22 9966 (For Senior Citizens) • Email: customersupport@tataaig.com • Website: www.tataaig.com
 IRDA of India Registration No.: 108 • CIN: U85110MH2000PLC128425 • UIN: TATHLIP23190V012223

Signature of Proposer & Date :

9. 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)

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)

Please fill an auto debit form for deduction of amount towards premium payment from bank account.

10. 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/we are aware of premium loading (if any declared above) for habits and diseases as declared/mentioned by me as above.
- Ayushman Bharat Health Account (ABHA) Declaration: I on behalf of all person(s) to be insured provide consent to access the medical and personal records/details [of all person(s) to be insured], as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider(s) of TATA AIG General Insurance

Company Ltd and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations.

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

- I understand that I will receive digital copy of my policy and service-related communication. However, I would prefer to also receive the physical copy of my policy and service-related communication and I want these documents to be shared via postal mail to the address as mentioned in this proposal form. For detailed terms, conditions, exclusions and policy wordings please refer our website (www.tataaig.com)

11. DECLARATION/VERNACULAR DECLARATION/DISABILITY 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 with Code: _____

Disability Declaration:

(Note: The below must be witnessed by someone other than the Advisor/Intermediary/Employee of the Company)

I certify that the replies in the Proposal Form have been recorded as per the information provided by me. I, (Full name of the representative) _____ (Relationship with the Proposer) _____, adult and inhabitant of (City) _____ residing at _____ do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the Insurance Policy from TATA AIG General Insurance Company Ltd., to the Proposer and they have understood the same. I declare that the facts stated herein are true and correct to the best of my knowledge and belief.

Signature of the Authorized Person: _____

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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Model Policy for HIV/AIDS and Persons with Disability, 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

15. ACKNOWLEDGEMENT (TO BE GIVEN TO CUSTOMER)

Proposal Number: _____

Date: _____

Name _____ of _____ the _____ Proposer

We acknowledge with thanks the receipt of your proposal for Model Policy for Persons with Disabilities and HIV/AIDS, Tata AIG General Insurance Company Limited 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 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.

Disclaimer: Insurance is the subject matter of the solicitation. For more details on benefits, exclusions, limitations, terms & conditions, please read the Policy Wordings carefully, before concluding a sale. Trade logo displayed above belongs to Tata Sons Private Limited and AIG and used by TATA AIG General Insurance Company Limited under License.

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