

City/Town		Pin Code	
District		State	
<<Current Country of Residence>>			
<<Residential address outside India>>			
Permanent Address	<input type="checkbox"/> If same as Residential Address, please tick here		
Landmark			
City/Town		Area	
District		Pin Code	

^Note:

- Here 'Address' implies the residential location/address where Insured Person(s) ordinarily resides in India. In case proposed prospect(s) reside at multiple addresses, then address of the person residing in the highest zone to be provided.
 Zone definitions as mentioned in the prospectus (wherein Zone A is highest followed by Zone B and Zone C respectively)
- Declared 'Address' will form the basis for the calculation of the premium.
- 'Address' is a material fact for calculation of the premium. "Material facts" for the purpose of this Policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.
- Any misrepresentation or misdescription of the same or established fraud by the policyholder may lead to termination of the policy as per policy terms and conditions and accordingly all premium paid thereon shall be forfeited to the Company.

Would you like to opt for Electronic Policy Issuance through an e-Insurance Account (eIA) of an Insurance Repository? Yes No

If you have an eIA, please provide following details:

Name of Insurance Repository	
eIA No	
Name as appearing in eIA	

If you do not have an eIA, would you like to open an account? Yes No

If Yes, choose any one Insurance Repository:

- NDML – NSDL Data Management Limited CAMSRep – CAMS Insurance Repository & Services
- KARVY Insurance Repository Limited CIRL – Central Insurance Repository Limited
- SHCIL Projects Limited

eIA (e-Insurance Account) helps customers manage all their insurance policies in a single digital account. It ensures safe, paperless storage and easy access to policy documents, while also enabling faster claims and service processing.

<input type="checkbox"/> TATA Group Employee	Employee ID:
Do you have an existing Group Mediciam Policy?##	<input type="checkbox"/> Yes, with TATA AIG <input type="checkbox"/> Yes, with insurer other than TATA AIG <input type="checkbox"/> No If yes, provide Group Mediciam Health Card/E-Card:
<input type="checkbox"/> Any existing policy with TATA AIG General Insurance Co. Ltd.	Product Name: Policy No (s):

##Note

- The applicability of the TransiCare Wallet Benefit shall be subject to verification of the information and/or documents submitted at the time of Policy Inception.
- The Group Mediciam Health Card/E-card submitted to the Company must pertain solely to the Proposer, who is also the Proposed Insured Person, and shall not belong to any third party.
- The TransiCare Wallet Benefit shall be available for selection only by a Proposer who is an Indian resident and is covered under a valid Group Mediciam (GMC) Policy.
- Insured Persons covered under the GMC Policy, who are Indian residents and whose details are duly verified based on the submitted documents (including but not limited to the Health Card/E-card), shall be eligible for the TransiCare Wallet Benefit.
- Mid-term endorsement of any existing Insured Person under the TransiCare Wallet Benefit shall not be permitted. Such endorsement, if any, shall be allowed only at the time of Policy Renewal, subject to the terms and conditions of the Policy.
- In the event of any misrepresentation, misdescription, or fraud in relation to the information or documents submitted for availing the TransiCare Wallet Benefit, the Company shall have the right, at its sole discretion, to recover, adjust, or retain any amounts payable under the Policy.
- The declaration of above details and its verification shall be required at the time of claim of the TransiCare Wallet benefit and also at each policy renewal, including all subsequent renewals, for the continued applicability of TransiCare Wallet.

2. POLICY DETAILS

Proposed Policy Commencement Date

d	d	m	m	y	y	y	y

Policy Tenure 1 Year 2 Year 3 Year 4 Year 5 Year

Sum Insured Type:

Floater Individual Multi-Individual
When more than one member are covered on individual basis

Floater Sum Insured (in ₹ Lakhs): 5 7.5 10 15 20 25 50 75 100 200
 300 500

Aggregate Deductible (in ₹ Lakhs) : 2 3 5 10 15 20 25 50

No Claim Bonus: Cumulative Bonus Discount in Renewal Premium

Room Category: Single Private Room Shared Accommodation Any Room

Your Premium shall be based on choice of Room Type that You make at the time of Proposal.

Zone: As applicable basis Permanent address Upgrade to Zone B*# Upgrade to Zone A**#

*#Can be opted if applicable zone basis address is Zone C

**#Can be opted if applicable zone basis address is Zone B or C

Note:

1. *The Policyholder/Proposer has the option to choose Zone A for premium payment, irrespective of Insured Person(s) location /address, which shall be designated as Pan India. This would entail that Co-payment for Treatment in Higher Zone would not be applicable. However once Zone A/Pan-India premium payment option has been selected then the Policyholder/Proposer will not have the option to shift to other premium payment zones at renewals*
2. *Aggregate Deductible is a cost sharing requirement under this policy which provides that We will not be liable for a specified amount in case of hospitalization/s during the policy year i.e. We will pay only if aggregate admissible claim amount in respect of hospitalization/s during the policy year exceeds the aggregate deductible as specified in the policy schedule. An Aggregate Deductible does not reduce the Sum Insured.*
3. *After completion of five continuous years of coverage under this Policy with Us and payment of applicable premium, the Policyholder will have the option to opt for waiver of the Aggregate Deductible on subsequent renewal(s). Please note that no credit for portability/migration shall be considered while calculating the five continuous Policy Years of coverage.*

4. You will have an option to choose either Cumulative Bonus or Discount in Renewal Premium only at the time of first claim free renewal of the policy. Once opted, the option cannot be changed at subsequent renewals.

<<Optional Covers:>>

S. No.	Benefits	Yes (Y) / No (N)
1	<<Consumables Benefit>>	Y/N
2	<<TransiCare Wallet>>	Y/N
3	<<Inbound Emergency Hospitalization>>	Y/N

Riders for <<product name >> (UIN:<<>>):

Rider Package Name	Rider Name	Cover/ Benefit Name	Coverage Limit
<input type="checkbox"/> <<Package 1>>	<<Name of the Rider 1>> <<UIN 1>>	<<Coverage Name 1>>	<<Coverage Limit options>>
		<<Coverage Name 2>>	<<Coverage Limit options>>
	<<Name of the Rider 2>> <<UIN 2>>	<<Coverage Name 1>>	<<Coverage Limit options>>
		<<Coverage Name 2>>	<<Coverage Limit options>>

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

Sr. No.	Name of the Proposed Insured Person	Gender	Relationship with Proposer*	Resident Status	Date of Birth	First Policy Inception date of Insured ⁵	Height	Weight	ABHA Number (14 digits) [^]	Sum Insured (In. ₹)	Aggregate Deductible (In. ₹)
1.		M / F/Others		<input type="checkbox"/> Indian <input type="checkbox"/> NRI <input type="checkbox"/> OCI <input type="checkbox"/> Others	dd/mm/yyyy	dd/mm/yyyy	(cms)	(Kgs)			
2.		M / F/Others		<input type="checkbox"/> Indian <input type="checkbox"/> NRI	dd/mm/yyyy	dd/mm/yyyy	(cms)	(Kgs)			

TATA AIG General Insurance Company Limited

Registered Office : Peninsula Business Park, Tower A, 15th Floor, G.K.Marg, Lower Parel, Mumbai - 400 013, Maharashtra, India. CIN: U85110MH2000PLC128425. IRDA of India Regn. No. 108. 24*7 Customer Support Number: 022 6489 8282 / 1800 267 1955 (only for senior citizen policy holders). • Email Id – customersupport@tataaig.com. • Website: www.tataaig.com IRDA of India Registration No.: 108 • CIN: U85110MH2000PLC128425 • TATA AIG MediCare Reserve UIN: TATHLIP27059V012627

				<input type="checkbox"/> OCI <input type="checkbox"/> Other s						
3.		M / F/Others		<input type="checkbox"/> Indian <input type="checkbox"/> NRI <input type="checkbox"/> OCI <input type="checkbox"/> Other s	dd/m m/yyyy	dd/mm/yyyy	(cms)	(Kgs)		
4.		M / F/Others		<input type="checkbox"/> Indian <input type="checkbox"/> NRI <input type="checkbox"/> OCI <input type="checkbox"/> Other s	dd/m m/yyyy	dd/mm/yyyy	(cms)	(Kgs)		
5.		M / F/Others		<input type="checkbox"/> Indian <input type="checkbox"/> NRI <input type="checkbox"/> OCI <input type="checkbox"/> Other s	dd/m m/yyyy	dd/mm/yyyy	(cms)	(Kgs)		

Note:

1. By selecting NRI/OCI as Resident Status, the proposed person(s) to be insured hereby acknowledge and confirm that their residency status is Non Resident Indian/Overseas Citizen of India
2. The following documents shall be submitted to the Company for verification at the time of Policy inception and at each subsequent renewal, as may be required by the Company:
 - a. Copy of a valid Passport along with applicable Visa stamping;
 - b. OCI Card, in case resident status is OCI;
 - c. Applicable tax documentation, valid Work Visa, or Employment/Work Permit evidencing residence and employment outside India;
 - d. A duly executed residential agreement (lease/rental agreement or ownership document) evidencing overseas residential address;
 - e. Any other document(s) as may be required by the Company from time to time for the purpose of verification of residency status.

***Allowed Relations**

Family Floater: Self, Spouse, Dependent Children,

<<[§] Please provide the member level first policy inception date only if it is not same for each proposed person to be Insured.>>

Individual: Self, Spouse, Dependent Children, Employee

For coverage of the below mentioned relationships, submit the listed documents:

Relationship	Documents to be submitted
Employee	Employment letter/ Appointment or Joining Letter/Last 3 months salary slips

^{^^}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	Name of the Nominee 1	Name of the Nominee 2
Date of Birth ¹		
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 Amount Payable		
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)

¹If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship	Address of the Appointee
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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
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Do you want Us to consider these details for portability? Yes No

Please note that continuity of benefits shall NOT be considered if the details are not provided. You need to approach Us at least 30 days prior to your expiry date to avoid any break in coverage. Please submit all previous year insurance policy copies.

Policy No.	Name of Proposed Insured Person	Insurer	Period of Insurance		Sum Insured (₹)	Cumulative Bonus (₹)	Aggregate Deductible (₹)	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 proposed Insured Person by ticking the relevant box.	Proposed Insured Persons				
	1	2	3	4	5

<<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/Insulin Dependent Diabetes >>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<< <input type="checkbox"/> Arthritis>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<< <input type="checkbox"/> COPD>>	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
<< <input type="checkbox"/> Liver Cirrhosis/Hepatitis B or C>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<< <input type="checkbox"/> Cancer>>	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
<< <input type="checkbox"/> Stroke, Epilepsy, Paralysis>>	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
<< <input type="checkbox"/> Ulcerative Colitis/Crohn's disease>>	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
<< <input type="checkbox"/> STDs>>	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
<<Are you or any persons proposed on regular medication (including any Ayurvedic treatment) or Hospitalized for any illness/surgery or awaiting any procedure/treatment?>>	Y/ N	Y/ N	Y/ N	Y/ N	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	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/ Type 2 Diabetes Mellitus/ Elevated Blood Pressure/ Hypertension/High Cholesterol/ Asthma/ >>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Have you or any members ever been diagnosed with Thyroid Disorder? If yes, please provide details for follow-up tests/medications>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Is any of the proposed 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

<<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	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
<<Have you undergone any annual health check-up or routine medical examination in the past year which showed any significant findings? If yes, please provide details for findings or results	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
Has the baby been diagnosed with and/or treated for any disease / illness during the gestation and /or post delivery period. If yes, please share the relevant Ante natal records, maternity discharge summary, investigation reports, treatment documents.	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
Do you suffer from any disability (If Yes, please tick/fill against the relevant section in the below and enclose Disability certificate issued by competent authority)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Disability	<ul style="list-style-type: none"> • Blindness • Handicapped • Hearing Impairment • Acid Attacks victims • Parkinson's Disease • Others Please specify) 	<ul style="list-style-type: none"> • Blindness • Handicapped • Hearing Impairment • Acid Attacks victims • Parkinson's Disease • Others Please specify) 	<ul style="list-style-type: none"> • Blindness • Handicapped • Hearing Impairment • Acid Attacks victims • Parkinson's Disease • Others Please specify) 	<ul style="list-style-type: none"> • Blindness • Handicapped • Hearing Impairment • Acid Attacks victims • Parkinson's Disease • Others Please specify) 	<ul style="list-style-type: none"> • Blindness • Handicapped • Hearing Impairment • Acid Attacks victims • Parkinson's Disease • Others Please specify)

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Percentage of Disability					
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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>>	<<Complication(s)>>

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

Proposed 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.

	Proposed Insured Person				
	1	2	3	4	5

<<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) • Per day • Per week • Per month • Occasionally>>	Quantity + Frequency + Duration				
---	---------------------------------------	--	--	--	--

7. PAYMENT DETAILS

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

Relationship with the proposer: (if different from proposer)

Total Premium Amount (in ₹)

Premium Payment Mode: Instalment Facility Limited Payment Facility Single
 Payment Mode

Frequency: <<Instalment Facility: Monthly Quarterly Half-Yearly Annual>>

<<Limited Payment Facility: 2 3 6 12 Instalments>>

<<Single Payment Mode: One time premium payment>>

Modal Premium (Including Tax) (in Rs.)

Instrument type: Cheque Debit Card Credit Card Net Banking 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 Declaration:

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.

Type of Organization making the payment (Please tick)

- Limited company
- Government organization
- Non-Governmental Organization (NGO)
- Society
- Trust
- Partnership
- International Organization
- Cooperatives
- Section 8 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)

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 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.
- Ayushman Bharat Health Account (ABHA) Declaration: I on behalf of all Proposed Insured Person(s) provide consent to access the medical and personal records/details [of all Proposed Insured Person(s)], 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
- 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)

Signature of the Proposer: _____

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

10. 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: _____

11. AGENT DECLARATION

Name _____ of _____ the _____ Proposer

We acknowledge with thanks the receipt of your proposal for TATA AIG MediCare Reserve 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.

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