TATA AIG Health SuperCharge

TATA AIG INSURANCE
WITH YOU ALWAYS

PROPOSAL FORM

URN No.: AH/2024-25/HL-01

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

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

Date of Birth: D D M M Y Y Y Y Gender: ☐ Male ☐ Female ☐ Others

Mobile No.: PAN Card:

Unique Govt ID No.:

Annual Income (in ₹ Lakhs): ☐ Upto 3 ☐ 3 to 6 ☐ 6 to 10 ☐ 10-15 ☐ 15-20 ☐ 20-25 ☐ >25

E-Mail ID:

Address^:

Landmark:

Area:

City/Town: Pin Code:

District: State:

Nationality: ☐ Indian ☐ Foreign Nationals

^ : Important Note:

- Here 'Address' implies the place where the person ordinarily resides. In case proposed insured person(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. However, this shall not be applicable if the proposer has opted for "Value Plan"
- '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 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.

TATA Group Employee ☐ TATA Group Employee ID: _____

2. POLICY DETAILS

Proposed Policy Commencement Date | D | D | M | M | Y | Y | Y | Y |

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

Floater Sum Insured (in ₹ Lacs) ☐ 5 ☐ 7.5 ☐ 10 ☐ 15 ☐ 20

Plan: ☐ Value Plan (For Zone A, B, C customers) ☐ Geo Plan (For Zone B, Zone C customers)

Room Category (Only available for Geo Plan): ☐ Single Private Room ☐ Shared Accommodation

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

Optional Covers: The below mentioned Optional Covers can be selected at policy level only.

S. No.	Benefits	Yes (Y) / No (N)	
1	Aggregate Deductible	Sum Insured (in ₹)	Deductible Options (in ₹) on floater basis
		5 Lacs	☐ 25000 ☐ 50000
		7.5 Lacs	☐ 37500 ☐ 75000
		10 Lacs	☐ 50000 ☐ 100000
		15 Lacs	☐ 75000 ☐ 150000
		20 Lacs	☐ 100000 ☐ 200000
2	Voluntary Sub-Limits	Y/N	
3	Emergency Air Ambulance Cover	Y/N	
4	Accidental Death Benefit	Y/N	
5	Restore Infinity	Y/N	
6	Consumables Benefit	Y/N	
7	Preventive Annual Health Check-Up	Y/N	
8	Advanced Cover	Y/N	

Note:

i. Aggregate Deductible is an irrevocable 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.

ii. Insured children or Insured person less than 18 years of age as on Policy commencement date will not be covered under Accidental Death Benefit.

iii. Optional Covers 1, 2, 3 & 4 as mentioned above, if opted shall continue for all the subsequent renewals of the policy, provided the policy is renewed with us without any break

iv. Optional Covers 5, 6, 7 & 8 as mentioned above, if opted at the first inception of this Policy with us, shall continue for all the subsequent renewals of the policy, provided the policy is renewed with us without any break. It cannot be opted at the time of renewal of the policy.

Add Ons for TATA AIG Health Supercharge :

☐ Waiver of Higher Zone Co-Payment – UIN: TATHLIA25019V012425

☐ Modification of Mandatory Sub-limits – UIN: TATHLIA25020V012425

The above-mentioned Add-On Cover(s) can be selected at policy level only and is applicable for Geo Plan only.

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

Sr No.	Name of the Insured Person	Gender	Relationship with Proposer*	Date of Birth	Height	Weight
1		M / F / Others		DD | MM | YYYY	cms	kgs
2		M / F / Others		DD | MM | YYYY	cms	kgs
3		M / F / Others		DD | MM | YYYY	cms	kgs
4		M / F / Others		DD | MM | YYYY	cms	kgs
5		M / F / Others		DD | MM | YYYY	cms	kgs

*Allowed Relations (Self, Spouse, child(ren), dependent Parents/ parents-in-law)

If the entry Age of the Insured Person is 61 years or above at the time of first coverage under this Policy, then such Insured Person shall bear 20% of each admissible claim (over and above any other Co-payment, if applicable).

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.

Nominee Name	Date of Birth*	Relationship	Address of the Nominee

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

Appointee Name	Relationship	Address of the Appointee

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

**Please note that continuity of benefits shall NOT be considered if the details are not provided. You need to approach Us 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		Sum Insured & Cumulative bonus (₹)	Aggregate Deductible (₹)	Claims lodged during the preceding year 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
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/Insulin Dependent Diabetes	Y/N	Y/N	Y/N	Y/N	Y/N
☐ Arthritis	Y/N	Y/N	Y/N	Y/N	Y/N
☐ COPD	Y/N	Y/N	Y/N	Y/N	Y/N
☐ Kidney Failure, Dialysis	Y/N	Y/N	Y/N	Y/N	Y/N
☐ Liver Cirrhosis/Hepatitis B or C	Y/N	Y/N	Y/N	Y/N	Y/N

☐ Cancer					
☐ HIV/AIDs	Y/N	Y/N	Y/N	Y/N	Y/N
☐ Stroke, Epilepsy, Paralysis	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
☐ Ulcerative Colitis/Crohn's disease	Y/N	Y/N	Y/N	Y/N	Y/N
☐ Auto-immune diseases	Y/N	Y/N	Y/N	Y/N	Y/N
☐ 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>> (Mandatorily "Yes", if 'Advanced Cover' is opted as Optional Cover for eligible members.)	Y/N	Y/N	Y/N	Y/N	Y/N
Have you ever been diagnosed with any Thyroid Disorder with or without any follow-up tests/medications?	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
EDD: DD/MM/YYYY	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
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? (If yes, please provide details of any findings or results)	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.)

Insured Name	Name of Disease (surgical)	Operative status	Type of surgery	Treatment status	Complication(s)

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

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.

	Insured Person				
	1	2	3	4	5
Alcohol (in ml) • Per day • Per week • Per month • Occasionally	Quantity + Frequency +Duration				
Smoking (No of Cigarettes or Bidis) • Per day • Per week • Per month • Occasionally	Quantity + Frequency +Duration				
Pan Masala/Tobacco (in gms) • 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)

Premium Amount (in ₹)

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.

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 (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:	☐ SB Account ☐ Current Account ☐ 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.

Signature of the 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 application form. For detailed terms, conditions, exclusions and policy wordings please refer our website (www.tataaig.com)

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 with Code: _____

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

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

TATA AIG Office Code: _____ Intermediary Code and Name: _____

Branch Receipt Date: _____ Channel Type: _____

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

R1/PF/TAHS/May 24

TATA AIG Health SuperCharge

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 proposal for TATA AIG Health Supercharge 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.

TATA AIG GENERAL INSURANCE COMPANY LIMITED

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IRDA of India Registration No: 108 | CIN: U85110MH2000PLC128425 | Tata AIG Health Supercharge UIN: TATHLIP24113V012324