THE ORIENTAL INSURANCE COMPANY LIMITED,
HEAD OFFICE: A-25/27, ASAF ALI ROAD, NEW DELHI 110002

CIN No.U66010DL1947GOI007158

MEDICLAIM INSURANCE POLICY (INDIVIDUAL)

PROPOSAL FORM

i. **PROPOSAL FORM AND SELF DECLARATION FORM TO BE FILLED IN BLOCK LETTERS AND IN DUPLICATE.**
ii. **PLEASE ATTACH TWO STAMP SIZE PHOTOGRAPHS OF EACH PERSON PROPOSED TO BE INSURED**
iii. **THE COMPANY WILL NOT BE ON RISK UNTIL THE PROPOSAL HAS BEEN ACCEPTED BY THE COMPANY AND COMMUNICATION OF THE ACCEPTANCE HAS BEEN MADE TO THE PROPOSER IN WRITING ON RECEIVING FULL PAYMENT OF PREMIUM.**
iv **ANY PERSON BEYOND 55 YEARS OF AGE DESIRING TO TAKE INSURANCE COVER HAS TO UNDERGO PRE INSURANCE MEDICAL CHECK UP THROUGH COMPANY'S LISTED DIAGNOSTIC CENTRE AND 50% OF THE COST OF SUCH EXPENSES TO BE REIMBURSED BY THE COMPANY AFTER ACCEPTANCE.**

1. NAME OF THE PROPOSER : Mr. / Mrs. / Miss

2. ADDRESS & TELEPHONE NO. / MOBILE NO. / E-MAIL ADDRESS:

												Mobile No											
Ph.No										E-mail													

3. PERMANENT ACCOUNT NO. (ISSUED BY INCOME-TAX AUTHORITIES):

4. NAME - ADDRESS & TELEPHONE NO OF FAMILY PHYSICIAN

Ph.No										Mobile No													

5. MONTHLY INCOME

6. NAME OF THE PERSON(S) PROPOSED TO BE INSURED AND RELATIONSHIP WITH THE PROPOSER.

S No	Name of the **persons proposed to be insured**	Relation ship with Proposer	Sex M/F	Whether dependa nt on the proposer Y / N	Date of Birth	Age (in complete d years)	Occupation	Sum Insured (Rs)	IF OPTED, **PERSONAL ACCIDENT (PA) SI** (Rs.)
1.									
2.									
3.									
4.									
5.									
6.									
7.									

7. VOLUNTARY CO-PAYMENT OPTED: IF YES, 10% / 20%

Signature of Proposer

8. PLEASE FURNISH DETAILS OF ANY HOSPITALIZATION / ILLNESS / DISEASE/ INJURY IN THE PAST (whether or not insurance existed)

S. No	Name of the proposed person	Name of the Insurer	Type of policy (Please specify) P.A., Cancer, Mediclaim, others)	Policy Number	Policy Period	Details of hospitalisation / disease / injury
1.						
2.						
3.						
4.						
5.						
6.						
7.						

9. **PLEASE GIVE THE DETAILS OF ANY HOSPITALISATION / ILLNESS/DISEASE/INJURY AT PRESENT OR IN THE PAST 4 YEARS. (whether or not insurance existed)**

S. No	Name of the proposed person	Name of the Insurer	Policy no.	Sum Insured	Period	Details of hospitalisation / disease / injury

10. HAS THE PROPOSER OR ANY OF THE MEMBERS OF THE FAMILY PROPOSED BEEN REFUSED INSURANCE FOR HEALTH COVER / POLICY CANCELLED / RENEWAL DENIED. IF SO DETAILS THEREOF:

S.No	Name of the Proposed person	Refusal by insurer & reasons thereof	Cancellation of policy / denial of renewal by the insurer & reasons thereof
1.			
2.			
3.			
4.			
5.			
6.			
7.			

11. Do you wish to opt out of TPA Service? **Yes** **No**

12. PROPOSED DATE & PERIOD OF INSURANCE (DD MM YYYY)

FROM									To								

Time 24hours

DECLARATIONS:

1. 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.
2. 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.
3. 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.
4. I declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority.

Place		Signature of Proposer.
Date		Name of Proposer

NOTE:

In case of death claims, the name of the beneficiary making claim, relationship with the insured and legal status is to be mentioned.

The claim for any of the insured person will be payable in the name of Proposer and discharge voucher signed by him will be considered valid. However, in the event of unfortunate demise of the Proposer during the course of policy period, the claim may be payable to the nominee declared by the Proposer in this form.

Nomination

In the event of my death, I nominate.....(Name & Relationship with the Insured) in respect of the amount payable by the Oriental Insurance Company Ltd under this policy and I further declare that his receipt shall be sufficient discharge to the Company.

Dated this.....Day of.....200.....at.....

Signature of Proposer

Signature of Witness:

Name and address

PROHIBITION OF REBATES (Section 41 of the Insurance Act 1938 provides)

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 the 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. Any person making default in complying with provision of this section shall be punishable with fine, which may extend to Rs.500/-.

SELF DECLARATION FORM

(FORM TO BE DULY FILLED & SIGNED BY EACH PROPOSED PERSON, IN DUPLICATE)

PERSONAL DETAILS:

1. Name of the Insured: _____
2. Age (in completed years): _____3. Date of birth: _____Sex: _____
4. Address: _____
_____
5. Telephone No.: _____E-mail ID: _____

Identification Document Details:(Photo ID Proof / Ration Card)_____

PERSONAL HISTORY: (For all insured persons listed in the proposal)

PARTICULARS	YES / NO	DETAILS
A. Are you in good health and free from physical and mental diseases or infirmity or major complaints?		
B. Have you ever suffered from any of the following diseases / illnesses. Please write **Yes** / **No.**		
1 Any Neurological / mental or related diseases?		
2 slipped disc or other spinal disorder or paralysis of any kind or fainting episode, blackout, fit.		
3 High blood pressure, palpitation, Heart diseases including ischaemic heart diseases, other circulatory disorders including rheumatic fever etc.		
4 Diseases of uterus, ovaries, breast or any other gynaecological disorder		
5 Fistula, Piles, Hernia, Varicose veins etc.		
6 Any disease of bones, joints, Arthritis including rheumatic diseases etc.		
7 Any respiratory diseases		
8 Any allergic diseases		
9 Any dimness of vision or cataract etc.		
10 Any disease of ears or difficulty or interference with hearing etc.		
11 Any disorder of the stomach, ulcer, bowel or gall bladder, kidney etc.		
12 Cancer, malignant growth, boil, cyst or wound etc.		
13 Diabetes or any urinary diseases.		
14 Genital Disorder		
15 Any cerebral or vascular strokes or sudden loss of consciousness or similar disease.		
16 Tuberculosis (TB)		
17 AIDS / HIV / related disorder etc.		
18 Congenital diseases (Since Birth)		
19 (a) Have you ever suffered from dental problems? YES/NO (b) If, yes, specify same. (c) When were you treated last for same.		
20 Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations.		
21 Any other complaint or tendency that may necessitate such consultation or treatment in the future		

(B) **Have you Noticed sudden decrease or increase in your weight in past six months** **Yes / No**

(C) Have you visited a doctor /hospital /healthcare unit for evaluation or treatment in recent past if yes, give details: _____
_____
_____

Give Details of hospitalization (Attach Copy of discharge card and doctors consultation notes and investigations copy): _____
_____
_____
_____

Past surgical details: Name of surgery or part operated _____
Date of operation: _____. Completely cured YES / NO, give details_____
_____

(Attach Copy of discharge card and doctor's consultation notes and investigations copy*)*

I the Undersigned hereby declare that all the information given by me in this form is true and I understand that any of these details if found untrue on correlation with my medical test or medical examination before or after issuance of policy will affect the coverage and payments of my health insurance benefit under this Mediclaim policy.

Signature:

Name of the person proposed to be insured _____

Date: Place: