National Insurance Company Limited

Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071
CIN - U10200WB1906GOI001713 IRDA Regn. No. - 58

National Parivar Mediclaim Policy

Proposal Form

(For office use only)

Intermediary Code	:	Issuing office code	
Development Officer Code	:	Issuing office address	
Policy Number	:		

IMPORTANT INSTRUCTIONS

(a) This Proposal Form will be the basis of the policy to be issued. It is therefore essential that all the information requested in this Proposal Form and all additional information relevant to the risk to be insured is provided fully & accurately. Please do not leave any space blank, or put dashes

(b) The Company will not be on risk until the Proposal have been accepted by the company and communication of the acceptance has been given to the proposer in writing after full payment of premium

(c) Details of upto 8 Insured Persons, including the proposer, can be filled in this Proposal Form. For additional members, please use a fresh form. Two stamp size photograph of each person are to be submitted, one of which is to be affixed on the Proposal form

(d) Persons 50 years of age and above or persons aged between eighteen years and sixty five years opting for the Critical Illness will have to submit pre policy checkup reports upto 1 month old

(e) Persons porting (switching) from health insurance policies of other non life insurance or stand alone health insurance companies must complete Annexure C (portability form) along with Proposal Form, Annexure A, B (if required)

(f) List of documents required is provided in Annexure D.

1. Proposer details (Please fill up in BLOCK LETTERS.)

Name of the Proposer : Mr./Mrs./Ms_____

Address : _____

_____

City : _____ District : _____

State : _____ PIN : _____

Telephone : _____ Mobile : _____

E -Mail : _____

Occupation : _____ PAN : _____

Period of Insurance _____(from) _____(to)

Name of nominee : _____

Relationship with proposer : _____ Age of nominee : _____

Name of the family medical practitioner : _____

Address : _____

Contact no. : _____

Sum insured *(applicable to entire family)* : _____

Premium paying zone : Zone I | Zone II | Zone III | Zone IV

Is TPA service required? : Yes | No (please strike through the one not required)

Policy duration : 1 year | 2 year | 3 year

Name in Bank Account : _____

Bank Name : _____

Bank Branch : _____

Account no : _____/_____/_____

MICR Code : _____ IFSC Code: _____

2. Insured Person Details

No. of persons covered (including proposer) ..... (in figure), ... (in words)

Paste one stamp size photographs and sign below (In case of minor, guardian or proposer may sign):

(Another stamp size copy of the same photograph is to be submitted with this proposal form, with the proposer/ insured person's name written on the reverse)

Proposer	*Insured Person 1*	*Insured Person 2*	*Insured Person 3*	*Insured Person 4*	*Insured Person 5*	*Insured Person 6*	*Insured Person 7*

All the fields are mandatory. Please do not leave any field blank.

Customer Code								
	Proposer	**Insured Person 1**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**	**Insured Person 7**
Name								
Date of Birth (mm/dd/yyyy)								
Age								
Gender (M/F)								
Height (cm)								
Weight (kg)								
Blood Group								
Marital Status								
Relationship with Proposer								
Dependent (Y/N)								
Occupation								
Do you smoke? (Y/N)								
Do you drink alcohol? (Y/N)								

3. Is proposer or any insured person an existing health insurance policyholder?
If yes, please give details below and attach policy copies.

	Company	**Policy No.**	**Policy Name**	**Expiry Date**	**Sum Insured**	**Bonus**	**Last Claimed Date**	**Claimed Amount**	**Porting? (Y/ N)**
Proposer									
Insured Person 1									
Insured Person 2									
Insured Person 3									
Insured Person 4									
Insured Person 5									
Insured Person 6									
Insured Person 7									

Please fill Annexure C if insured is porting from other Insurance Company to our company

4. Medical history of proposer and insured person. Write Yes/ No.
Please do not leave the spaces blank.

	Proposer	**Insured Person 1**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**	**Insured Person 7**

Are you in good health, free from physical and mental disease or infirmity or medical complaints?									
Yes/ No	:								
If 'No', have you ever diagnosed with any of the following disease / illness? Write 'Yes' with duration (mm/yyyy to mm/yyyy) where applicable.									
(a) Psychiatric disorder	:								
(b) Slipped disc or other spinal disorder or paralysis	:								
(c) Fistula, Piles, Hernia, Varicose veins	:								
(d) Disease of bone or joint including rheumatic disease	:								
(e) Disease of uterus, ovaries or breast or any specific gynaecological disorders	:								
(f) Respiratory or allergic disease	:								
(g) Any disorder of the stomach, ulcer, bowel or gall bladder, kidney stones etc.	:								
(h) Cancer, boil, cyst or wound etc. which does not heal or improve despite treatment	:								
(i) Dimness of vision / cataract	:								
(j) Disease of ears or difficulty with hearing	:								
(k) Diabetes or urinary disease	:								
(l) Any other illness, disease, accident or operation sustained	:								
(m) Any complaint that may necessitate treatment in the future	:								

5. If diagnosed with any of the following diseases or any other pre existing disease/ condition, write Yes/ No. If 'Yes' please write date first diagnosed and fill Annexure A & B separately for each individual with adverse medical history or pre existing disease/ condition.

	Diabetes	Hypertension	Chest pain	Coronary insufficiency	Myocardial infarction	Any other condition?
Proposer						
Insured Person 1						
Insured Person 2						
Insured Person 3						
Insured Person 4						
Insured Person 5						

Insured Person 6						
Insured Person 7						

6. **In case the Proposer/ Insured Person is 50 years of age and above or persons aged between eighteen years and sixty five years opting for the Critical Illness, pre policy checkup reports dated not more than 30 days prior to date of proposal for the following test are submitted? Write Yes/ No.**

	Physical examination (signed by `Doctor with min MD (Medicine) qualification)	Blood sugar (fasting & post prandial)	Urine routine and microscopic examination	Lipid profile	Serum creatinine	ECG	Eye check up including retinoscopy
Proposer							
Insured Person 1							
Insured Person 2							
Insured Person 3							
Insured Person 4							
Insured Person 5							
Insured Person 6							
Insured Person 7							

7. **Optional Cover**

Critical Illness Yes No

If 'Yes', please fill us the following table with details of the insured person for whom critical illness cover is sought.

	Proposer	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7
Sum insured (shall be limited to the sum insured under the policy)								
Any other critical illness policy?								
If 'yes', write Company name Policy number Sum insured								
If any claim under the above policy, name the disease								
If you smoke, specify the average number of cigarette/tobacco/cigar smoked during a day								
If you drink, specify the type (beer, wine, spirits) and your average daily consumption								
Medical history	Write 'Yes', or 'No'							
(a) Do you suffer from hypertension?								
(b) Do you suffer from								

Diabetes?								
(c) Do you suffer from any cardiac ailment?								
(d) Do you suffer from cancer?								
(e) Do you suffer from kidney failure?								
(f) Do you suffer from multiple sclerosis?								
(g) Do you suffer from Hear and/or Circulatory disease?								
(h) Do you suffer from Diabetes or any other disease affecting a. Lungs, b. Blood c. Liver, d. Glands e. Joints.								
(i) Do you suffer from any other disease / ailment? (Please write name of disease / ailment)								

Out-patient treatment (applicable to the entire family) Yes No

Sum insured for Outpatient treatment _____

Cover for pre existing disease from inception. Write Yes/ No.

	Diabetes	Hypertension
Proposer		
Insured Person 1		
Insured Person 2		
Insured Person 3		
Insured Person 4		
Insured Person 5		
Insured Person 6		
Insured Person 7		

8. Declaration

I/We 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/we am/are 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 insurance policy and that the policy will come into force only after full receipt of the premium chargeable.

I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the proposer or from any past or present employer concerning anything which affects the physical or mental health of the proposer and seeking information from any insurance company to which an application for insurance on the proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

I/We 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 : ....
Date : ...../...../..... **Signature of Proposer**

Name of the Proposer (in BLOCK LETTERS) .....

In case Proposal Form is not completed by proposer

As per clause no. 3.(4) of Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002, - 'where, for any reason, the proposal and other connected papers are not filled by the proposer, a certificate may be incorporated at the end of proposal form from the proposer that the contents of the form and documents have been fully explained to him/her and that he/she has fully understood the significance of the proposed contract'

Certificate from proposer in case proposal form is not filled by him/ her

The proposal form is filled up by my representative, but the contents of the documents have been fully explained to me and I am willing to accept the coverage subject to terms, conditions and exceptions prescribed by the Insurance Company therein.

Place : ....
Date : ...../...../..... **Signature of Proposer**

Name of the Proposer (in BLOCK LETTERS) .....
N.B. : This should necessarily be signed by proposer, and not by his/her representative.

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 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 prospectus or tables of the Insurers.**
2. **Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to five hundred rupees.**

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Gross Premium	:	`. .....
Premium for add on covers	:	`. .....
Net premium payable	:	`. .....

Policy No. :
Name of Insured Person :

To be completed by proposer in case of pre existing conditions and for adverse history in respect of any illness

Diabetes Questionnaire

1	Date of first diagnosis of diabetes	:
2	Do you take any anti diabetic drugs?	:
	If so, please give name with dose	:
3	Please give details of fasting and postprandial blood Sugar readings, E.C.G. findings and other investigation reports with dates, please also send reports	:
4	Please state whether you have been diagnosed with any complications of diabetes.	:

Hypertension Questionnaire

1	Date of first diagnosis of hypertension	:
2	What is your blood pressure reading? Please state with dates	:
3	Please state names of anti hypertensive drugs with dose?	:
4	Are you a smoker?	:
5	Is it essential /secondary/malignant hypertension?	:
6	Please state whether you have been diagnosed with any complications of hypertension.	:
7	Please give findings of all investigation reports	:

Chest Pain or Coronary Insufficiency or Myocardial Infarction Questionnaire

1	Date of first diagnosis Did you ever suffer from chest pain or coronary insufficiency or myocardial infarction? If so, please give diagnosis and date.	:
2	Please state the name and dose of drugs you are taking at present.	:
3	Please state the findings with dates of investigations done like ECG, stress test, coronary angiography, X-ray, pathology reports etc. please send reports with the Proposal form.	:
4	Please state the date of hospitalisation and names of hospitals and consultants.	:
5	Please state complications and other related disease, if suffered.	:
6	Please state whether you can do your regular work and whether you have any limitation of activity.	:
7	Are you advised any special treatment? If so, please give information.	:

Any other pre existing condition

1	Nature of illness/ disease/ injury and treatment received	:
2	Date of first diagnosis.	:
3	Whether fully cured?	:

Place :

Date :

_____
Signature of Proposer

Policy No. :
Name of Insured Person :

To be completed by consulting physician / surgeon in case of adverse medical history

1	**Name of the Insured Person**	:
2	**History**	
(a)	**Present complaints and investigation, if any**	:
(b)	**Any past history of disease, operations, accidents, investigations with date, major medical complaints of hospitalisation?**	:
(c)	**Details of present and past medication with duration**	:
(d)	**Is he cured of diseases, if any?**	:
	When was your treatment, if any, given, stopped?	:
3	**General examination**	:
4	**Systematic examination**	:

Signature of Proposer

.....

Date :
Place :

Signature of Consulting Physician

.....

Name of consulting Physician:
Qualifications :
Address :
Telephone Number :

TO BE COMPLETED BY OFFICIAL OF INSURANCE COMPANY

Do you consider the risk acceptable?

Competent Authority:

Branch Manager:

Divisional manager:

Policy No. :
Name of Insured Person :

To be completed by the insured in case of porting from a health insurance policy issued by another insurance company

Portability Form

1)	Name of the Policyholder / insured (s)	
2)	Date of Birth/Age	
3)	Address of the policyholder/insured	
4)	Details of existing insurer	
	i. Name of insurance company	
	ii. Name of the product	
	iii. Sum Insured	
	iv. Cumulative Bonus	
	v. Add-ons/riders taken	
	vi. Policy number	
5)	Details of the proposed insurance	
	i. Name of the product proposed/intend to take	
	ii. Sum Insured Proposed	
	iii. Whether Cumulative Bonus to be converted to an enhanced sum insured	
6)	Reason(s) for Portability	
7)	No. of family members to be included in the policy to be ported	
Enclosure: Photocopy of the existing & previous policy documents		
Date: Signature of the policyholder		

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy? (Please indicate Yes / NO):

2. If yes, please give written consent to the declaration below:

I am aware that the waiting period for the following disease(s)/treatment(s) is more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s).

Name of disease/ treatment	Waiting period in days/ years
1. 2. 3. 4.	

Place :

Date :

_____

Signature of the policyholder

Documents required

1. Completed proposal form
2. Cancelled cheque (supporting bank account details)
3. Stamp size photograph (2 nos) for each insured person
4. Pre policy check up reports (if applicable)
5. Copy of existing health insurance policies (if applicable)
6. Proof of identity (any one document listed below)
7. Proof of residence (any one document listed below)
8. Pan Details (in case PAN not available, Form 60 or 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted)

Documentary proof

Features	Documents
Proof of identity	i. Passport ii. PAN Card iii. Voter's Identity Card iv. Driving License v. Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer vi. Personal identification and certification of the employees of the insurer for identity of the prospective policyholder. vii. Letter issued by Unique Identification Authority of India containing details of name, address and Aadhar number viii. Job card issued by NREGA duly signed by an officer of the State Government
Proof of Residence	i. Telephone bill pertaining to any kind of telephone connection like, mobile, landline, wireless, etc. provided it is not older than six months from the date of insurance contract ii. Current Passbook with details of permanent/present residence address (updated upto the previous month) iii. Current statement of bank account with details of permanent/present residence address (as downloaded) iv. Letter from any recognized public authority v. Electricity bill vi. Ration card vii. Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof viii. Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)
Proofs of both Identity and Residence	Written confirmation from the banks where the proposer is a customer, regarding identification and proof of residence.