UNITED INDIA INSURANCE COMPANY LIMITED

REGISTERED & HEAD OFFICE: 24, WHITES ROAD, CHENNAI-600014

IRDA Registration No. 545

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 shall be the basis of the policy to be issued. It is therefore essential that all the information sought 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 has 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 up to 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) Pre-policy health checkup reports not older than 30 days are required to be submitted in case of proposals for persons above the stipulated age or in case of enhancement of Sum Insured beyond the specified limit as explained in prospectus.

(e) Fresh proposal form is required along with pre acceptance medical check-up as mentioned in item (d) above, when there is break in insurance cover.

(f) 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)

(g) 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** : _____

AADHAAR (UID) No. : _____ **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 : _____

Is TPA service required? : Yes No

Proposer's 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*	*Insured Person 8*

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**	**Insured Person 8**
Name								
Date of Birth (dd/mm/yyyy)								
AADHAAR No.								
Age								
Gender (M/F)								
Height (cm)								
Weight (kg)								
Blood Group								
Marital Status								
Relationship with Proposer								
Dependent (Y/N)								
Occupation								
Do you smoke? (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									
Insured Person 8									

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**	**Insured Person 8**
Are/Is you/the person proposed for insurance in good health and free from physical and mental disease or infirmity or medical complaints? If no, please give details									
Yes/ No	:								
Have you/ the persons proposed for insurance ever been diagnosed with any of the following disease(s) / illness(es)? Write 'Yes' with name of illness(es) and duration (mm/yyyy to mm/yyyy) where applicable.									
(a) Psychiatric disorder	:								
(b) Slipped disc or other spinal disorder or paralysis	:								
(c) Disease of Prostrate /Fistula, Piles, Hernia, Varicose veins /Genital diseases	:								
(d) Disease of bones/ joint including rheumatic, slipped disc, spinal disorder, injury to ligaments	:								
(e) Disease of uterus, ovaries or breast or any specific gynecological disorders	:								
(f) Respiratory or allergic disease	:								
(g) Any disorder/ disease of the stomach, Intestine, Liver, Gall bladder, Pancreas, kidney, Urinary Bladder, urinary Tract	:								
(h) Cancer, Pre-Cancerous Lesion, boil, cyst or wound etc. which does not heal or improve despite treatment	:								
(i) Cataract and other diseases of the eye	:								
(j) Difficulty with hearing, ENT diseases	:								
(k) Gynaecological disorder such as DUB, Fibroid Uterus, Ovarian cyst - or have undergone caesarean / Hysterectomy	:								
(l) Any other illness, disease, accident or surgery/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 Mellitus	Hypertension	Chest pain	Coronary insufficiency	Myocardial infarction	Any other condition (including AIDS)?
Proposer/ Insured Person 1						
Insured Person 2						
Insured Person 3						
Insured Person 4						
Insured Person 5						
Insured Person 6						
Insured Person 7						
Insured Person 8						

6. Pre policy checkup reports dated not more than 30 days prior to date of proposal for the following test are submitted, if applicable? Write Yes/ No.

	Physical examination	HbA1c	Urine routine and microscopic examination	Lipid profile	Serum creatinine	ECG	Any other report as demanded by the Company
Proposer/ Insured Person 1							
Insured Person 2							
Insured Person 3							
Insured Person 4							
Insured Person 5							
Insured Person 6							
Insured Person 7							
Insured Person 8							

7. Add ons:

A. Ambulance Charges Yes No

B. Hospital Daily Cash Yes No

B.1: Hospital Daily Cash Allowance Opted: Rs. 250 per day subject to a maximum of Rs. 2500 per person policy period.
OR Rs. 500 per day subject to a maximum of Rs. 5000 per person policy period.
(Strike off whatever not opted for from the above)

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 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.

Submitted the above proposal along with payment of Rs. _____ by cash/vide cheque /DD no/ _____ dated _____ drawn on _____. I understand that the cash/cheque given is banked for operational convenience and commencement of risk is subject to the acceptance of proposal by you.

I also confirm that the source of funds for premium paid under this policy is legal.

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

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

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

(As required to comply with clause no. 6 (4) of Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017)

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.

9. Declaration of the Intermediary: I / We confirm that I have explained the product features to the proposer and its suitability him and other insured persons.

Place : ……. **…….**
Date : ……/……/…….. **Signature of Intermediary**

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 ten lakh 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 :

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Do you consider the risk acceptable?

Competent Authority:

Branch Manager:

Divisional manager:

United India Insurance Co. Ltd. Annexure C

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.