United India Insurance Company Limited
Regd. Office: 24 Whites Road, Chennai, 600 034

Super Top-Up Medicare Policy

Proposal Form

Important Instructions

(Please read the instructions below carefully before filling out this form)

- This Proposal Form shall be the basis of the policy to be issued. Thus, please provide all the information sought in this Proposal Form & all additional relevant information fully & accurately. Please do not leave any space blank or put dashes.
- 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.
- Details of up to 6 Insured Persons, including the proposer, can be filled in this Proposal Form. For additional members, please use a fresh form.
- Pre-policy health check-up 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 the prospectus.
- Persons porting (switching) from similar deductible based 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).
- List of documents required is provided in Annexure D.

I. Proposer Details

(Please submit a copy of Aadhaar/Passport/Election Photo ID Card/Latest Electricity Bill/Bank Pass Book as Proof of Address)

Name: .....

Date of Birth: DD/MM/YYYY Gender: ☐ Male ☐ Female ☐ Transgender Marital Status: ☐ Single ☐ Married

Occupation: ☐ Salaried ☐ Self-Employed ☐ Others, please specify .....

PAN Card No: ..... Aadhaar Card/Passport No: ..... E-Insurance Account No. ..... *(if available)*

Address: .....

.....

City: ..... District: ..... State: ..... Pin Code: .....

Tel. No. (with STD Code): ..... (Home) ..... (Mobile)

E-mail: .....

II. Nomination

(Please enter nominee details for the Proposer. For other members, the proposer is deemed to be the nominee)

Nominee Name: ..... Nominee Relationship: .....

Nominee Address: .....

..... Nominee Contact No: .....

III. Coverage Details

(Sum Insured is in Rs. Lacs)

Cover Type: ☐ Individual Sum Insured Basis ☐ Family Floater Basis

The following Threshold/SI combinations are available:

Threshold	SI Options
2 Lacs	3 Lacs, 5 Lacs
3 Lacs	3 Lacs, 5 Lacs, 7 Lacs
5 Lacs	5 Lacs, 10 Lacs, 15 Lacs, 20 Lacs, 45 Lacs, 70 Lacs and 95 Lacs
10 Lacs	10 Lacs, 15 Lacs, 20 Lacs, 40 Lacs, 65 Lacs and 90 Lacs
15 Lacs	15 Lacs, 35 Lacs, 60 Lacs and 85 Lacs
20 Lacs	20 Lacs, 30 Lacs, 55 Lacs, 80 Lacs
25 Lacs	25 Lacs, 50 Lacs, 75 Lacs

Important Note: Please enter the Threshold/SI combination you require in the table provided under Section IV (Insured Person Details). In case you are opting for policy on Family Floater basis, enter the Threshold/SI combination under Proposer only. In case you are opting for policy on Individual Sum Insured basis, enter the Threshold/SI combination for each of the Insured persons.

Optional Cover required for Daily Cash Allowance on Hospitalisation: ☐Yes ☐No

Coverage required from ..... am/pm of DD/MM/YYYY to midnight of DD/MM/YYYY

IV. Insured Person Details

No. of Persons Covered (including proposer): _____ (in figures) _____ (in words)

Please paste a stamp size photograph and sign for each insured person in the box provided in the next page. In case of minor, guardian/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 back of the photograph.

Proposer Photo	*Insured Person 2 Photo*	*Insured Person 3 Photo*	*Insured Person 4 Photo*	*Insured Person 5 Photo*	*Insured Person 6 Photo*
Signature					

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

Customer Code						
Details	**Proposer**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**
Name						
Date of Birth (DD/MM/YYYY)						
AADHAAR No.						
Age						
Gender (M/F)						
Sum Insured						
Threshold						
Height (cm)						
Weight (kg)						
Blood Group						
Marital Status						
Relationship with Proposer						
Dependent (Y/N)						
Occupation						

V. Existing/Previous Insurance Policy Details

Does any person proposed to be insured presently hold a health insurance policy from any insured (including UIIC)? ☐ Yes ☐ No
If yes, please give details below:

Details	**Proposer**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**
Company						
Policy No.						
Policy Name						
Expiry Date						
Sum Insured						
Threshold/ Deductible						
Last Claimed Date						
Claimed Amount						
Porting/Migrating (Y/N)						

Kindly fill Annexure C if insured is porting from another insurer to UIIC.
Please note that the continuity of benefits shall NOT be considered in the following cases: a) the above question is not replied in the affirmative; b) Details are not provided; c) Portability Form (Annexure C) and relevant supporting documents are not submitted to UIIC.

VI. Medical Information

Medical History of Proposer and Insured Persons. Tick Yes/No. Please do not leave the spaces blank

	Proposer	*Insured 2*	*Insured 3*	*Insured 4*	*Insured 5*	*Insured 6*
Are/Is you/the person proposed for insurance in good health and free from physical and mental disease or infirmity or medical complaints	Y N	Y N	Y N	Y N	Y N	Y N
Have any of the persons who are proposed for insurance ever suffered from/are suffering from any of the following:						
Psychiatric Disorder	Y N	Y N	Y N	Y N	Y N	Y N

	Proposer	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Genetic Disorders	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus, Hypertension	Y N	Y N	Y N	Y N	Y N	Y N
Blood Disorder, HIV/AIDS, Venereal Diseases	Y N	Y N	Y N	Y N	Y N	Y N
Diseases of Cardiovascular system, Heart diseases	Y N	Y N	Y N	Y N	Y N	Y N
Disease of Prostate/Fistula, Piles, Hernia, Varicose Veins	Y N	Y N	Y N	Y N	Y N	Y N
Disease of bones/joint including arthritis, rheumatic pain, slipped disc, spinal disorder, injury to ligaments or paralysis	Y N	Y N	Y N	Y N	Y N	Y N
Nervous Disorders, Epilepsy	Y N	Y N	Y N	Y N	Y N	Y N
Any disorder/disease of the stomach, intestine, liver, gall bladder, pancreas, kidney, urinary bladder, urinary tract	Y N	Y N	Y N	Y N	Y N	Y N
Tumour, Cancer, Pre-cancerous lesion, ulcer, boil, cyst or wound etc. which does not heal or improve despite treatment	Y N	Y N	Y N	Y N	Y N	Y N
Cataract and other diseases of the eye	Y N	Y N	Y N	Y N	Y N	Y N
ENT Diseases, Respiratory or allergic disease	Y N	Y N	Y N	Y N	Y N	Y N
Gynaecological disorder such as DUB, Fibroid Uterus, Prolapsed Uterus, Ovarian cyst – or have undergone caesarean/Hysterectomy	Y N	Y N	Y N	Y N	Y N	Y N
Thyroiditis/Goitre	Y N	Y N	Y N	Y N	Y N	Y N
Any other illness, disease, accident or surgery/operation sustained?	Y N	Y N	Y N	Y N	Y N	Y N
Any complaint that may necessitate treatment in the future?	Y N	Y N	Y N	Y N	Y N	Y N

If you answered 'Yes' to any of the questions above, please give details in the table below. Additionally, also submit Annexure A, B.

Name of the Persons to be insured	Illness	Date of Last Consultation (DD/MM/YYYY)	Treatment Undergone	Name of the treating Doctor	Hospital Name, Phone No.	Present Status

Information on Habits. Please tick Yes/No and answer the questions, if applicable.

Does the applicant/any of the persons proposed to be insured consume any of the following?

	Proposer	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Chewable Tobacco / Gutkha / Pan Masala	Y N	Y N	Y N	Y N	Y N	Y N
Alcohol	Y N	Y N	Y N	Y N	Y N	Y N
Cigarettes	Y N	Y N	Y N	Y N	Y N	Y N
Illegal Drugs	Y N	Y N	Y N	Y N	Y N	Y N

If you answered 'Yes' to any of the questions above, please give details below on the quantity consumed per week.

Chewable Tobacco/Gutkha/Pan Masala:
Alcohol:
Cigarettes:
Illegal Drugs:

Family History

Have any first-degree relatives of ANY of the persons proposed to be insured suffered or are suffering from Cancer, Diabetes, Hypertension, heart disease, kidney disease, stroke, multiple sclerosis or any other hereditary disorders? ☐ Yes ☐ No

If Yes, please give details in a separate sheet on the relationship to the insured person, the diagnosed disease, age of the affected member and cause of death (if applicable).

Past Proposals

Has any proposal for life, health or critical illness insurance for any of the persons proposed to be insured ever been declined, postponed, loaded or made subject to any special conditions by any insurance company? ☐ Yes ☐ No

Pre-Policy Check-up Reports. Please tick Yes/No if the relevant documents for that test are submitted, if applicable.

The reports should not be dated more than 30 days prior to the date of proposal.

Proposer Insured 2 Insured 3 Insured 4 Insured 5 Insured 6

Physical Examination	Y N	Y N	Y N	Y N	Y N	Y N
Complete Blood Count	Y N	Y N	Y N	Y N	Y N	Y N
Urine Routine and Microscopic Examination	Y N	Y N	Y N	Y N	Y N	Y N
HbA1c (Blood Sugar)	Y N	Y N	Y N	Y N	Y N	Y N
Lipid Profile	Y N	Y N	Y N	Y N	Y N	Y N
Serum Creatinine	Y N	Y N	Y N	Y N	Y N	Y N
SGOT & SGPT	Y N	Y N	Y N	Y N	Y N	Y N
ECG (Electrocardiogram)	Y N	Y N	Y N	Y N	Y N	Y N
Any other report as required by UIIC	Y N	Y N	Y N	Y N	Y N	Y N

VII. Payment and Bank Account Details

Premium Amount (₹): _____ (in words) _____

Premium Payment Options: ☐ Annual ☐ Half-Yearly ☐ Quarterly ☐ Monthly

Premium Payment Modes: ☐ Cash ☐ Cheque ☐ DD ☐ Credit/Debit Card ☐ ECS

Cheque No.: _____ Date: DD/MM/YYYY

Credit/Debit Card No. _____ Card Type: ☐ Visa ☐ Master Card Expiry Date: DD/MM/YYYY

Bank Name: _____ Bank Account No: _____

VIII. Declaration (Please read carefully and tick against each statement before signing the proposal form)

☐ 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 any time 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.

I/We declare that I/We have Submitted the above proposal along with payment of ₹ _____ 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.

Date: DD/MM/YYYY Place: _____ Signature of the Proposer: _____

Name of the Proposer (in BLOCK letters): _____

IX. Vernacular Declaration

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.

Date: DD/MM/YYYY Place: _____ Signature of the Proposer: _____

Name of the Proposer (in BLOCK letters): _____

Please note that this should necessarily be signed by the proposer and not his/her representative

X. Declaration from Intermediary

I/We confirm that I/We have explained the product features to the proposer and its suitability to him/her and other insured persons.

Date: DD/MM/YYYY Place: _____ Signature of Intermediary: _____

XI. Statutory Warning (Section 41 of Insurance Act, 1938 – Prohibition of Rebates)

- 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.
- Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

XII. Office Use Only

Gross Premium: _____ Net Premium: _____

Intermediary Code: _____ Development Officer Code: _____

Issuing Office Code: _____

Issuing Office Address: _____

_____

XIII. Checklist (Please refer to Annexure D for a detailed list on what constitute as valid documents)

Please ensure all the following documents are attached along with the completed proposal form.

☐ Proof of Identity

☐ Proof of Residence

☐ Proof of Age

☐ Photocopies of all previous, existing health insurance policies and endorsements, if applicable

☐ Cancelled cheque (supporting bank account details)

☐ 2 Stamp size photographs for each insured person (one of which to be pasted in Section IV)

☐ Pre-Policy Check-up Reports, if applicable

☐ PAN Details (in case PAN not available, Form 60 or 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted)

Acknowledgement by the Company

Date: DD/MM/YYYY

We acknowledge the receipt of your proposal and amount by Cash/Cheque/Others _____ of amount of

Rs. _____ dated DD/MM/YYYY

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought 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 premium is not received by us in full and in time or is not realized. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.

This Annexure is to be completed by EACH insured person who has answered 'Yes' to any of the questions in Section VI (Medical History) or has any pre-existing conditions/adverse history in respect of any illness.

Name of Insured Person: _____

Diabetes Questionnaire

- Date of 1st Diagnosis of Diabetes : _____
- Do you take any anti-diabetic drugs? If so, please give name with dosage : _____
- Please give details of fasting and postprandial blood sugar readings, E.C.G. findings & other investigation reports with date. Please also send reports : _____
- Please state whether you have been diagnosed with any complication of diabetes? : _____

Hypertension Questionnaire

- Date of 1st Diagnosis of Hypertension : _____
- What is your blood pressure reading? Please state with dates : _____
- Please state names of anti-hypertensive drugs with dosage details : _____
- Are you a smoker? : _____
- Is it essential/secondary/malignant hypertension? : _____
- Please state whether you have been diagnosed with any complication of hypertension? : _____
- Please give findings of all investigation reports : _____

Chest Pain or Coronary Insufficiency or Myocardial Infarction Questionnaire

- Date of 1st Diagnosis Did you ever suffer from chest pain/coronary insufficiency/myocardial infarction? If so, please give diagnosis and date. : _____
- Please state the name and dose of drugs you are taking at present : _____
- 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. : _____
- Please state the date of hospitalisation and names of Hospitals and consultants : _____
- Please state complications and other related disease, if suffered. : _____
- Please state whether you can do your regular work and whether you have any limitation of activity? : _____
- Are you advised any special treatment? If so, please give information : _____

Any other Pre-Existing Condition

- Nature of illness/disease/injury & treatment received : _____
- Date of 1st Diagnosis : _____
- Whether fully cured? : _____

Date: DD/MM/YYYY Place: _____ Signature of Insured Person: _____

This Annexure is to be completed by the consulting physician/surgeon if ANY of the insured persons have answered 'Yes' to any of the questions in Section VI (Medical History) or have any pre-existing conditions/adverse history in respect of any illness.

- Name of the Insured Person :

History

- Present complaints and investigation, if any? :
- Any past history of disease, operations, accidents, investigations with date, major medical complaints of hospitalisation? :
- Details of present and past medication with duration :
- Is he/she cured of diseases, if any? When was your treatment, if any, given, stopped? :
- General Examination :
- Systematic Examination :

Signature of Consulting Physician **Signature of Proposer**

Name of Consulting Physician: **Place:**

Qualifications **Date:** DD/MM/YYYY

Address:

Telephone No:

Office Use Only

Do you consider the risk acceptable?

Competent Authority:

Branch Manager:

Divisional Manager:

This Annexure is to be completed by the policyholder who is porting from a health insurance policy issued by another insurance company

Name of Policyholder: _____

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**	
	a. Name of insurance company	
	b. Name of the product	
	c. Sum Insured	
	d. Cumulative Bonus	
	e. Add-ons/riders taken	
	f. Policy Number	
5.	**Details of the Proposed Insurance**	
	a. Name of the product proposed/intended to take	
	b. Sum Insured proposed	
	c. 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**		

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

  _____

- 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 the Disease / Treatment	Waiting Period in Days / Years
1. 2. 3. 4.	

Date: DD/MM/YYYY Place: _____ Signature of Policyholder: _____

This Annexure details the list of documents that are required along with this proposal form and the documents that are considered as valid

Documents Required

- Completed Proposal Form
- Cancelled Cheque (supporting bank account details)
- Stamp Size Photograph (2 no.) for each insured person
- Pre-Policy Check-up reports (if applicable)
- Copy of existing health insurance policies (if applicable)
- Proof of Identity (any one document listed below)
- Proof of residence (any one document listed below)
- 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. Aadhaar Card vii. Job card issued by NREGA duly signed by an officer of the State Government
Proof of Residence	i. Passport ii. Driving License iii. Aadhaar Card iv. Voter's Identity Card v. Job card issued by NREGA duly signed by an officer of the State Government vi. Letter issued by National Population Register containing details of name and address Where the above documents do not have the updated address, the following documents shall be deemed to be valid documents for the purpose of Proof of Residence. i. Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone, piped gas, water bill) ii. Property or Municipal Tax receipt iii. Pension or family pension payment orders (PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address iv. Current Photo Passbook with details of permanent/present residence address (updated up to the previous month) v. Current statement of bank account with details of permanent/present residence address (as downloaded) 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