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aj Allianz General Ins				<u> </u>	: Road, Ye	rawac	da, Pur	ne - 41	1 006.										Scru	itiny	No.	_	Rec	eipt	No.	+	Poli	cy No).
r Agent Use Only:	:																	For	Ane	ent U	se () nlv:							
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Instructions Fo	or Filling	Up The	e Fori	m:-																									
 The Liabi This Prop ACCURAT 	osal will b	Compa e the b hat you	any do basis o u prov	oes no of any /ide u	ot comm subsequ	nence uent	polic	cy tha	it we i	issue	e to y	/ou. l	lt i	ccepted by the C s therefore essen levant to risk to b	tial th	at yo	ou pr	ovid	e all	thei	info	rmat	ion i						
Proposer Detai	ls																												
1) Full Name:	Title													First Name															
Middle Name														Surname															
2) Are you an e	victing Bai	iai Allia	nz Cu	istom	or: Voc	/ No	Ifvor	nloa	so m	ontic	on th	o Do	lic	v No: OC															
, , <u>,</u>				-			,		1	_	JI U			y NO. OG					Na									1	
3) Gender:	Male	Fema		Oth	er	4) Date	e of B	irth [D	D	M	N	Y Y Y	Y		,	PAN	I							Ļ	<u> </u>		
6) UID/Unique I	D:										7) Ba	ajaj A	lli	anz Employee Co	de, if	Prop	oser	is B/	AGIC	/BAL	IC E	mpl	oyee		L				
8) Marital Status	s: Ma	arried	S	Single	Di	ivorc	ed	W	/idow	ed		9) N	١o	. of Children	Sons		[Daug	ghte	rs									
10) Occupation	Bus	iness	Sá	alarie	d	Pro	fessio	onal		Stud	lent]	House Wife	Ret	ired		0	the	°S									
11 a) Permane	nt / Resid	ential	Addre	ess										11 b) Correspo	ndeno	e Ad	ldres	is: (A	All th	e com	mur	icatio	ons wi	ill be s	ent t	o the	belov	w add	ress)
House No.					use									House No.						Но									
Landmark/					me 📖									Landmark/						Nar	ne								
Locality Road/			-			+		1						Locality Road/															1
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12) Educational	Qualificat	ion:	Ma	tricul	ate			Und	ler Gra	adua	ate			Graduate			[Pos	t Gra	dua	te	[Profe	essio	nally	Qua	alified
13) Family Mon	thly Incom	ne:	Up	to Rs	. 20,000)		Rs. 2	20,00	1 to	Rs. 5	50,00	0	Rs. 50,00	1 to R	s. 1 la	akh [Abc	ve R	s. 1	lakh							
14) In case of ar	y Offer, yo	ou wou	ld pre	efer to	be con	tacte	ed by:	:	Phon	ie [Emai	il	15)Nationality															
16) Details of t	he nersor	is to he	insu	red																									
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r O	Name				DOB (dd/mm	n	Age		ender M/F)	ŀ	łt	Wt		Occupation	R	elati	on			Sum sure			Prem	nium	N	omir	nee		ations Nomi
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17) Period of Ins	surance: F	rom	D	D N	M.	Y	Y	Y	Y T	ō	D	D	M	M Y Y	Y Y														
18) Co-Paymen	t (Waiver	for non	-netw	vork F	lospital	s) [ΠY	/es] No																				
						(chev	wing	paste	2)/al	coho	ol, ni	cotin	ie	or marijuana in a	ny foi	m?											Y	es	No
Please give			-											· .													_		
hepatitis, di backache, a 21) Have you or	the heart, sorder of u ny conger any of yo	or circu urinary hital/ bi	ulator tract irth de	ry syst or kid efects	tem, che dneys, bl s/ urinar	est pa lood ry dis	ain, h disor eases	nigĥ b rder, a s, AID	lood any m S or p	pres ienta oosit	sure al or ive H	e, stro psyc HIV, I	oke chi f y	e, asthma any res atric conditions, a es, indicate in the ster) have/ had c	any di e table	sease give	e of b en be	orain low	orı	nervo	ous	syste	m, fi	ts (e	pilep		slipp Ye	ed di es] No
																										L	Ye	es	No
Prior to age If yes please pro	-	ile																											

22) Please confirm, if an	y of the person to	be insured is pregnant	(For Females Only)If yes,	please state how many months?_

23) Do you or any of the family members to be covered have/had any health complaints/met with any accident in thepast 4 years and have been taking treatment/ hospitalization? (Please provide details in the table given below)

24) Illness/injury details of the past 4years and prior to 4 years.

Sr. No	Name of the person	Name of the Illness /injury suffered / suffering in the past 4 years	Treatment details	Date first treated	Name of the Illness / injury suffered any time in the past (prior to 4 years)	Treatment details	Date first treated	Current Status of the Illness/ Diseases/Injury

25) Has any proposal for life, critical illness or health related insurance on your life or lives ever been postponed, declined or accepted on special terms? If yes, give details

26) Family Docto	r Det	tails:																	
Name:																			
Qualification:													M	obile					
Address:																			
Reg No:																			

Voluntary Deductible

Deductible Amount in Rs Please tick the opted deductible Discount (%)

Deductible Amount in Rs	10,000	15,000	25,000	50,000	75,000	100,000	150,000	200,000	250,000
Please tick the opted deductible									
Discount (%)	10.00%	15.00%	17.50%	20.00%	22.50%	25.00%	27.50%	30.00%	32.50%

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 company 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 life to be insured/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 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.

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.

Date

Signature of Proposer

Name and Designation:

Place :___

Insurance Act, 1938 Section 41 - 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 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 FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO FIVE HUNDRED RUPEES. Certified that the contents of the Proposal Form and documents have been fully explained to the Proposer and that he/they have fully understood the significance of the proposed contract***

T.

Date :	
Place :	Signature of Proposer
Name and Designation:	

*** This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer.

** Please read declaration wordings carefully before signing the proposal form.

Yes No

Yes	No
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PORTABILITY FORM

-	_	-
DA	DT	
FA		

1)	Name of the Policyholder / insured (s)
2)	Date of Birth / Age
3)	Address of policyholder / insured
4)	Details of existing insurer
	i. Name of the product
	ii. Sum Insured
	iii. Cumulative Bonus
	iv. Add ons/Riders taken
	v. Policy Number
5)	Details of the proposed insurance
	i. Name of the product proposed/intended to take
	ii. Sum insured proposed
	iii. Whether Cumulative Bonus to be converted to an enhanced sum insured
6)	Reason (s) of portability

7) No of family member to be included in the policy to be ported_

		Health ID			Period of	First	
First Name of Insured	Details of Previous Health Insurance Policy / Policy No.	Card number	Sum Insured	СВ	From dd/mm/yyyy	To dd/mm/yyyy	Policy inception date

Enclosure: Photocopy of the existing policy documents

Date	D	D	Μ	М	Y	Y	Y	Y

PART II

 Whether the PED exclusions / time bound exclusion have longer exclusion period than existing policy (Please indicate Yes /No) 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) isdays/years more than the previous policy terms, I hereby agree to observe the additional waiting period for the following diseases (s)/ treatments (s)

Signature of Policyholder

Signature of Proposer