THE ORIENTAL INSURANCE COMPANY LIMITED

Regd. Office: Oriental House, P.B. No. 7037, A -25/27, Asaf Ali Road, New Delhi – 110002

CIN No. U66010DL1947GOI007158

AROGYA SANJEEVANI - ORIENTAL

PROPOSAL FORM

i. PROPOSAL FORM AND SELF DECLARATION FORM TOBE FILLED IN BLOCK LETTER AND IN DUPLICATE.

ii. PLEASE ATTACH TWO STAMP SIZE PHOTOGRAPHS OF EACH INSURED PERSON.

iii. THE COMPANY WILL NOT BE ON RISK UNTIL THE PROPOSAL HAS BEEN ACCEPTED BY THE COMPANY AND COMMUNICATION OF THE ACCEPTANCE HAS BEENMADE TOTHE PROPOSER IN WRITING ON RECEIVINGFULL PAYMENT OF PREMIUM.

iv ANY PERSON BEYOND 55 YEARS OF AGE DESIRING TO TAKE INSURANCE COVER HAS TO UNDERGO PRE INSURANCE HEALTH 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 INSURED PERSON AND RELATIONSHIP WITH THEPROPOSER.

S. No	Name of Insured person	Relationship with Proposer	Gender M/F/TG*	Dependent on Proposer- Y/No	Date of Birth	Age in completed years	Occupation
1.							
2.							
3.							
4.							

5.							
6.							
7.							

***Third gender**

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

***Pin Code is mandatory field**

												Mobile No												
Ph.No										E-mail														
*Pin Code No																								

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

4. NAME - ADDRESS &TELEPHONE NO. OF FAMILYPHYSICIAN

Ph.No												Mobile No												

5. PLEASE GIVETHE DETAILS OF ANY HOSPITALISATION/ILLNESS/DISEASE/CLAIM AT PRESENT OR IN THE PAST SIX YEARS.

S.	First Name of the insured	Name of the	Policy	Policy Period	Type of	Sum	Illness/

No		Insurer	no.		policy (Please specify) P.A., Cancer, Mediclaim, others)	Insured	disease

6. HAS THE PROPOSER OR ANY OF THE MEMBERS OF THE FAMILY PROPOSED FOR INSURANCE BEEN DENIED COVER FOR SIMILAR PROPOSAL/POLICY BEEN CANCELLEDBY INSURER. IF SO DETAILSTHEREOF:

S.No	First Name of the person proposed for insurance	Denial by insurer (Name of Insurer)	Cancellation of policy by Insurer (Name of Insurer)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

7. Do you wish to opt for TPA Service?

YES	NO

8. **PROPOSED DATE &PERIOD OF INSURANCE (DD MMYYYY)**

FROM								To								

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/proposerafter 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 pastor 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.

6. I have carefully read the Prospectus and having understood the same, I propose for a policy in the standard form issued by the Company.

Place		Signature of Proposer.
Date		Name of Proposer

NOTE:

1. In the event of a claim under the policy exceeding Rs.1 lac or a claim for refund of premium exceeding Rs.1lac, the insured will comply with the provisions of the AML policy of the Company. The AML policy is available in all our operating offices as well as Company's website (www.orientalinsurance.co.in).

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

3. 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

I .... do hereby nominate

.... (Relationship with the Proposer) 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)

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 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.

2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to Ten Lakh Rupees.

Vernacular Declaration:

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent/employee of the company):
Name of Proposer:

The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same.

Signature of Proposer:		Name & Signature of the witness:	
Date:		Place:	

AGENT'S DECLARATION

I,..(Full Name) in my capacity as an Insurance Agent/ /Authorised employee of the Broker/, do hereby declare that I have explained in detail the features of the products and all the contents of this Proposal Form, alongwith the nature of questions contained in the Proposal Form to the Prospect, and also the fact that this Proposal form will form the basis of the Insurance contract between the Oriental Insurance Company Ltd and the Proposer, if this Proposal Form is accepted by the Company for issuance of the policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished and further more if there has been a non-disclosure of any material fact, the policy issued pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.
License No. (Agent/Corporate Agent/Broker):

Signature of Agent		Signature of Proposer	
Date:		Place:	

SELF DECLARATION FORM

(FORM TO BE DULY FILLED IN BY EACH APPLICANT ONLY IN DUPLICATE)

PERSONAL DETAILS:

1. Name of the Person to be insured:____

2. Age incompleted years:_________3. Date of birth:_______________4.Gender:__________

5. Address:____

____

6. TelephoneNo.:____________________7. E-mail ID:________________________________

8. Identification Document details:(Photo ID Proof / Ration Card)_________________________

A. PERSONAL HISTORY: (For each of the person listed in the Proposal Form)

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 Ischemic 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 the 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		
22	Smoking		
23	Alcohol Consumption		

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

ii. Please confirm your Body Mass Index (BMI) Range :- **Yes/No**

a. Greater than or equal to 40

b. Greater than or equal to 35 with any of the following severe co morbidities:-

1. Obesity related cardiomyopathy
2. Coronary heart disease
3. Severe Sleep Apnea
4. Uncontrolled Type 2 Diabetes

(C) Have you visited a doctor /hospital /healthcare unit for evaluation or for treatment in the last 12 months if yes, give details: ____

____

____

(D) Give Details of hospitalization (Attach Copy of discharge card and Doctors consultation notes and investigations):______________________________________

____

____

_____ ____

(E) Past surgical details: Name of surgery or Body 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 claim/benefit under this Policy.

Name of applicant:____Signature:

Date: Place: