THE ORIENTAL INSURANCE COMPANY LIMITED,
HEAD OFFICE: A-25/27, ASAF ALI ROAD, NEW DELHI 110002

Oriental Super Health Top-Up!

PROPOSAL FORM

Unique Reference No.OICL/HEALTH/PROP/18-19/01

1. PROPOSAL FORM AND SELF DECLARATION FORM TO BE FILLED IN BLOCK LETTERS AND IN DUPLICATE.
2. PLEASE ATTACH TWO STAMP SIZE PHOTOGRAPHS OF EACH INSURED PERSON.
3. THE COMPANY WILL NOT BE ON RISK UNTIL THE PROPOSAL HAS BEEN ACCEPTED BY THE COMPANY AND COMMUNICATION OF THE ACCEPTANCE MADE TO THE PROPOSER IN WRITING ON RECEIVING FULL PAYMENT OF PREMIUM.
4. ANY PERSON WITH ADVERSE MEDICAL HISTORY IRRESPECTIVE OF AGE AND ALL PERSONS BEYOND 55 YEARS OF AGE, DESIRING TO TAKE INSURANCE COVER HAS TO UNDERGO PRE INSURANCE HEALTH CHECK UP AT COMPANY'S LISTED DIAGNOSTIC CENTRE. 50% OF THE COST OF SUCH EXPENSE WILL BE REIMBURSED BY THE COMPANY AFTER ACCEPTANCE OF PROPOSAL AND PAYMENT OF PREMIUM.

1. NAME OF THE PERSON TO BE INSURED AND RELATIONSHIP WITH THE PROPOSER

S. No	Name of person to be Insured	Relationship with Proposer	M/F/TG*	Date of Birth	Age in completed years	Sum Insured**	Deductible**
1.							
2.							
3.							
4.							
5.							
6.							

***Trans gender**
****Sum Insured & Deductible may vary if Individual Plan is opted**

2. PLAN OPTED:

INDIVIDUAL YES/No	FAMILY FLOATER YES/No	whether proposed names are dependent on Proposer YES/No

3. WHETHER ROOM RENT LIMIT TO BE DELETED: (ON PAYMENT OF ADDITIONAL PREMIUM)

YES	**NO**

4. ADDRESS & OTHER CONTACT DETAILS:

												Mobile No												
Ph.No																								
E-mail																								
Fax																								

5. PERMANENT ACCOUNT NO. (PAN) OF THE PROPOSER:

6. AADHAR NO. OF THE PROPOSER

7. DO YOU HAVE AN EXISTING HEALTH POLICY: Y / N

8. IF YES, PLEASE GIVE FOLLOWING DETAILS in respect of each name proposed for insurance:

Name of person to be insured	Name of Insurer	Name of the Policy	Policy No	Policy Period	Sum Insured (in lakhs)	TPA

9. NAME - ADDRESS & TELEPHONE NO. OF FAMILY PHYSICIAN (If Any)

Ph.No

Mobile

10. PLEASE FURNISH DETAILS OF ANY HOSPITALIZATION / PRE-EXISTING DISEASE/ ILLNESS SUFFERED / CONTRACTED IN THE PAST FOUR YEARS.

Sl.No.	Name of the person to be insured	Injury / Disease suffered	Hospitalisation Period
1			
2			
3			
4			
5			
6			

11. PLEASE GIVE INSURANCE DETAILS (If Any) OF ABOVE CLAIM(S)

S.No	Name of the proposed insured person	Name of the Insurer	Sum Insured (in Lakhs)	Policy no.	Policy Period	Claim Status – Paid amount / Denied
1						
2						
3						
4						
5						

12. HAS ANY INSURER DENIED / CANCELLED COVER OF THE PROPOSER OR ANY OF THE FAMILY MEMBERS PROPOSED FOR INSURANCE. IF SO DETAILS THEREOF:

S. No	Name of the proposed insured person	Denial / Cancellation	Name of Insurer

13. PROPOSED DATE & PERIOD OF INSURANCE (DD MM YYYY)

FROM									TO								

14. 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 payment 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/proposer after the proposal has been submitted but before communication of the risk acceptance by thecompany.
4. I declare that I consent to the company seeking medical information from any doctor or hospital who/which at anytime has attended on person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I declare that I give consent to the company that if any of the pre- exiting disease declared by me, falls under the list of diseases given under "Clause 5" of the Policy document, the specific ICD codes for that particular disease mentioned therein, will be permanently excluded from the policy coverage.
6. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority.
7. 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 lakh or a claim for refund of premium exceeding Rs. 1 lakh, 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 on Company's website.
2. 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 unfortunate event of 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.

15. NOMINATION

I .....do hereby nominate ..... Relationship with the Insured) and I further declare that his receipt shall be sufficient discharge to the Company.
Dated this.....Day of.....200.....at.....

Signature of Proposer		Name of Witness	
Signature		address of Witness	

16. PROHIBITION OF REBATES (Section 41 of the Insurance Act 1938 provides)

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 default in complying with provision of this section shall be punishable with fine, which may extend to Rs.10,00,000/-.

17. 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:	

18. 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
(TO BE DULY FILLED IN BY EACH APPLICANT (Person proposed to be Insured) **INDIVIDUALLY IN DUPLICATE)**

PERSONAL DETAILS:

1. Name of the Person proposed to be Insured: _____
2. Age in completed years:_____3. Date of Birth:_____Gender: _____
4. Address: _____
5. Telephone No.:_____Mobile No: _____
6. E-mail ID _____

Identification Document Details:(Photo ID Proof / Ration Card)_____

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

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 ischaemic 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, details of problem. (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 Do You smoke / drink alcohol		

(B) Have you Noticed sudden decrease or increase in your weight in pastsix months Yes / No

(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*)*

1. **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 benefit under this policy.**
2. **I do hereby solemnly declare that all Pre-existing diseases have been declared and explicit information of such disease given in the above columns where the information has been sought.**
3. **I, give consent that if any of the pre- exiting disease declared by me, falls under the list of diseases given under "Clause 5" of the Policy document, the specific ICD codes for that particular disease mentioned therein, will be permanently excluded from the policy coverage.**

Name of applicant_____Signature:

Date: Place: