

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

### MEDICAL INSURANCE PROPOSAL FORM

**PROPOSAL FORM NO.** 

DATE:

- 1. FORM TO BE FILLED IN BLOCK LETTERS.
- 2. PLEASE SUBMIT TWO STAMP SIZE PHOTOGRAPHS OF EACH INSURED PERSON ALONGWITH TWO COPIES OF PROPOSAL FORM. NAME AND AGE OF THE INSURED MUST BE WRITTEN ON THE BACK OF THE PHOTO.
- 3. 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 ON RECEIVING FULL PAYMENT OF PREMIUM.
- 4. IN CASE OF ADVERSE MEDICAL HISTORY ANNEXURE 'A' TO BE COMPLETED BY THE CONSULTING PRACTITIONER (NOT BELOW MD) AND TO BE SUBMITTED BY THE PROPOSER.
- 5. ANNEXURE 'A' IS ALSO TO BE OBTAINED FOR PERSONS AGED ABOVE 50 YEARS AND BE SUBMITTED ALONGWITH LATEST ECG PRINT OUT WITH REPORT AND FASTING BLOOD SUGAR TEST AND URINE STRIP TEST REPORT OR ANY OTHER MEDICAL REPORT REQUIRED BY THE COMPANY.

#### 1. NAME OF THE INSURED PERSON AND RELATIONSHIP WITH THE PROPOSER.

S. No.	N	ame	e of t	the	insu	ired	ľs /	pro	pos	er				Relation ship with Proposer	Sex M/F	D	ate	of E	Birth	1	Age	Occup ation	Sum Insure d (Rs)
1.																							
2.																							
3.																							
4.																							
5.																							
6.																							
7.																							

#### 2. ADDRESS & TELEPHONE NO. / MOBILE NO. / E-MAIL ADDRESS

								Мо	bile r	10					
Ph.	No					E-n	nail								

#### 3.PERMANENT ACCOUNT NO. (ISSUED BY INCOME-TAX AUTHORITIES)

#### 4.NAME - ADDRESS & TELEPHONE NO OF FAMILY PHYSICIAN

Ph	.No						oile N	ю					

# 5.PLEASE FURNISH DETAILS OF ANY OTHER INSURANCE AT PRESENT OR PAST AND CLAIM DETAILS IN THE PAST YEARS.

S. No	Fi	rst	Na	me	of t	the	ins	ure	d	N	ame	e of	the	In	sure	er			Type of policy (Please specify) P.A., Cancer, Mediclaim others)	Policy Number	Policy Period
1.																					
2.																					
3.																					
4.																					
5.																					
6.																					
7.																					

### 6.CLAIM DETAILS IF ANY OF INSURED

S.No. of Proposer	First	Nai	me	of 1	Гhe	Ins	sure	d	Amount of Claim	Policy No.	Policy Period	Ailment for which amount claimed
1.												
2.												
3.												
4.												
5.												
6.												
7.												

## 7. PLEASE ANSWER THE FOLLOWING QUESTIONS IN YES / NO

	SEI	RIAL NO	OF PERS	SON IN PA	ARA (1)		
PARTICULARS	1	2	3	4	5	6	7
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 diseasee / illnesses. Please encircle							
the disease and write <b>Yes</b> otherwise write <b>No</b> .							
1 Any Neurological / mental or psychiatric							
diseases?							
2 slipped disc or other spinal disorder or							
paralysis of any kind or fainting episode,							
blackout, fit.							
3 High blood pressure, 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.							
6 Any disease of bones, joints Arthritis							
including rheumatic diseases etc.							
7 Any respiratory or allergic diseases							
8 Any dimness of vision or cataract etc.							
9 Any disease of ears or difficulty or							
interference with hearing etc.							
10 Any disorder of the stomach, ulcer, bowel							
or gall bladder, kidney etc.							
11 Cancer, malignant growth, boil, cyst or							
wound etc.							
12 Diabetes or any urinary diseases.							
13 Any cerebral or vascular strokes or similar							
disease.							
14 (a) Have you ever suffered from dental							
problems? YES/NO							
(b) If, yes, specify same.							
(c) When were you treated last for same.							
15 Any other complaint requiring specialist's							
consultation or surgical or hospital							
treatment or investigations.							
16 Any other complaint or tendency that may							
necessitate such consultation or treatment							
in the future							

# 8. PLEASE GIVE DETAILS OF DISEASES/ ILLNESSES/INJURIES DEFORMITIES ETC DECLARED YES IN COLUMN NO. 7.

S.No	Nan	ne o	f the	e ins	urec	l pei	rson	I	Nature of illness / disease / injury	Date when first treated	Name & Address Of attending medical practitioners	Whether fully cured
1.												
2.												
3.												
4.												
5.												
6.												
7.												

# 9. PLEASE STATE THE NAME OF PRE-EXISTING DISEASES / ILLNESS/ INJURIES SUFFERED / SUFFERS BY THE PROPOSER.

S.No	Fir	st N	ame	e of t	the i	nsu	red	oers	on	Name of disease / illness /injuries.	Remarks
1.											
2.											
3.											
4.											
5.											
6.											
7.											

# 10. ARE THERE ANY ADDITIONAL FACTS EFFECTING THE PROPOSED INSURANCE WHICH SHOULD BE DISCLOSED TO THE INSURERS.

S.No	Fir	st N	ame	e of t	the i	nsu	red	pers	on	Remarks
1.										
2.										
3.										
4.										
5.										
6.										
7.										

### 11. PLEASE GIVE THE DETAILS OF EXISTING MEDICLAIM POLICY.

S.No	Fir	st N	lame	e of t	the i	nsu	red	pers	on	Name of the Insurer	Policy no.	Sum Insured	Period	Remarks
1.														
2.														
3.														
4.														
5.														
6.														
7.														

# 12. HAS THE PROPOSAL OF ANY OF THE MEMBERS OF FAMILY PROPOSED BEEN REFUSED/ HIGHER PREMIUM CHARGED OR FACED DIFFICULTY IN SIMILAR PROPOSAL DUE TO:

S.No	Fir	st N	ame	e of t	he i	nsui	red		Refusal by insurer	Higher premium charged on a/c of high claim ratio	Cancellation of policy by insurer
1.											
2.											
3.											
4.											
5.											
6.											
7.											

# 13. NAME OF THE NOMINEE IN THE EVENT OF DEATH OF INSURED DURING THE COURSE OF TREATMENT.

S.No.	First Name of the Insured								Name of the Beneficiary								Relation with Insured	
1.																		
2.																		
3.																		
4.																		
5.																		
6.																		
7.																		

### 14. PROPOSED DATE & PERIOD OF INSURANCE( DD MM YY)

FROM To	
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I/we declare that the statements made by me/us in this proposal form are true and to the best of my / our knowledge and belief and I/we hereby agree that this declaration shall form the basis of the contract between me/us and The Oriental Ins.Co.Ltd.. I / we also declare that if any additions or alterations are carried out after the submission of this proposal form and /or issuance of policy document, the same would be conveyed to the The Oriental Insurance Company immediately. I further consent and authorize the Oriental Insurance Company Limited and/or any of its authorized representative to seek medical information from any hospital/medical practitioner who has attended or may attend in future concerning any disease or illness. I further declared that I have read the prospectus and have understood the same. I accept the policy, subject to terms, exceptions and conditions prescribed therein and further disclose that on the event of finding any thing contrary to what has been declared by me, I shall be held responsible for all consequences thereof and insurance company shall incur no liability under this insurance.

Place	Signature of Proposer.
Date	Name of Proposer

#### INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATES

Section 41 of the Insurance Act 1938 provides as follows:

Any person making default in complying with provision of this section shall be punishable with fine which may extend to Rs.500/-.

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.

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ANNEXURE - A

### MEDICAL CERTIFICATE TO BE COMPLETED BY CONSULTING PHYSICIAN NOT BELOW MD.

S.No.		1.	2.	3.	4.	5.	6.	7.
1.	Name of the							
	Insured							
2.	Age							
3.	Any Past History of diseases / operations / investigation / accident / investigation with date and major complaints.							
4.	Details of past medication							
5.	Blood Pressure							
6.	Pulse							
7.	General Examination							
8.	Systemic Examination							
9.	ECG Report and observation							
10.	Blood / Urine Report							
11.	Present complaints investigation, if any.							
12.	Details of present medication.							
13.	Remarks.							

Signature of Poposer

NAME OF THE PROPOSER

Signature of Physician

Name, Address and Seal of physician with Registration No.

Place:

Date: