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

HAPPY FAMILY FLOATER POLICY – 2015

WE VALUE YOUR HEALTH & YOUR WEALTH…BUILD A PRODUCTIVE NATION

PROPOSAL FORM

i. **PROPOSAL FORM AND SELF DECLARATION FORM TO BE FILLED IN BLOCK LETTERS 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 BEEN MADE TO THE PROPOSER IN WRITING ON RECEIVING FULL PAYMENT OF PREMIUM.**
iv **ANY PERSON BEYOND 60 /55 YEARS OF AGE (DEPENDING ON THE PLAN OPTED) 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 THE PROPOSER.

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. PLAN OPTED:

S.no.	Plan (S /G/ D)**	Sum Insured under the Plan (Rs. in lacs)

****S-SILVER, G-GOLD, D-DIAMOND**

3. OPTIONAL COVERS:

A.

Restoration of SI	**YES**	**NO**
If Yes	**50% of SI**	**100% of SI**

B.

Life Hardship Survival benefit	**YES**	**NO**
IF YES	**PLAN A**	**PLAN B**

C.

Sl.No.	Personal Accident	
	Name	SI (Rs. in lacs)
1.		
2.		
3.		
4.		

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

Mobile No

Ph.No E-mail

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

6. NAME - ADDRESS & TELEPHONE NO. OF FAMILY PHYSICIAN

Ph.No Mobile No

7. PLEASE GIVE THE DETAILS OF ANY HOSPITALISATION/ILLNESS/DISEASE AT PRESENT OR IN THE PAST SIX YEARS.

S. No	First Name of the insured	Name of the Insurer	Policy No.	Policy Period	Type of policy (Please specify) P.A., Cancer, Mediclaim, others)	Sum Insured	Illness/ disease

8. HAS THE PROPOSER OR ANY OF THE MEMBERS OF THE FAMILY PROPOSED FOR INSURANCE BEEN DENIED COVER FOR SIMILAR PROPOSAL/POLICY BEEN CANCELLED BY INSURER. IF SO DETAILS THEREOF:

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.			

9. Do you wish to opt for TPA Service?

YES	NO

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

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/proposer after 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 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.
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.1 lac, 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...................Year..................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.

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 in completed years: ___________3. Date of birth: _________________4. Gender: __________
5. Address: ____
____
6. Telephone No.: ______________________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 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, 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		

(B) Have you noticed sudden decrease or increase in your weight in past six 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*)*

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: