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

HEALTH OF PRIVILEGED ELDERS

(SENIOR CITIZEN SPECIFIED DISEASES INSURANCE)

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 ON THE ENROLMENT FORM.**

iii. **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.**

iV. **THE INSURED HAS TO UNDERGO PRE INSURANCE HEALTH CHECK UP THROUGH COMPANY'S AUTHORISED DIAGNOSTIC CENTRE AND 50% OF THE COST OF SUCH EXPENSES IS TO BE BORNE BY THE COMPANY. LIST OF SUCH DIAGNOSTIC CENTRES WILL BE PROVIDED.**

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

S. No.	Name of the insured	Relation ship with Proposer	Sex M/F	Date of Birth	Age (in completed years)	Occupation	Sum Insured (Rs)
1.							
2.							
3.							
4.							
5.							
6.							
7.							

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

	Mobile No
Ph.No	E-mail

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

4. NAME - ADDRESS & TELEPHONE NO OF FAMILY PHYSICIAN

Ph.No	Mobile No

5.PLEASE FURNISH DETAILS OF ANY HOSPITALIZATION / ILLNESS / DISEASE AT PRESENT OR IN THE PAST.

S. No	**Name of the insured**	Name of the Insurer	Type of policy (Pleas specify) P.A., Cancer, Mediclaim, others)	Policy Number	Policy Period
1.					
2.					
3.					
4.					
5.					
6.					
7.					

6. **PLEASE GIVE THE DETAILS OF ANY HOSPITALISATION/ILLNESS/DISEASE IN THE PAST 4 YEARS.**

S. No	**First Name of the insured**	**Name of the Insurer**	**Policy no.**	**Sum Insured**	**Period**	**Remarks**
1.						
2.						
3.						
4.						
5.						

SIGNATURE OF PROPOSER

7 HAS THE PROPOSER OR ANY OF THE MEMBERS OF THE FAMILY PROPOSED BEEN REFUSED COVER FOR SIMILAR PROPOSAL. IF SO DETAILS THEREOF:

S.No	First Name of the insured	Refusal by insurer	Cancellation of policy by insurer
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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

FROM									To								

DECLARATIONS:

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/We am/are 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/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.

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."

Place		Signature of Proposer.
Date		Name of Proposer

NOTE:
In case of death claims, the name of the beneficiary making claim, relationship with the insured and legal status is to be mentioned.
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 assign the amount payable by the Oriental Insurance Company Ltd under this policy in the event of my death to .....(.....Relationship to 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

Signature of Witness
Name and address

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.500/-.

SELF DECLARATION FORM

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

PERSONAL DETAILS:

1. Name of the Insured: _____
2. Age (in completed years): _____3. Date of birth: _____Sex: _____
4. Address: _____
_____
5. Telephone No.: _____E-mail ID: _____

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

6. PERSONAL HISTORY:

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 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) **<u>Have you Noticed sudden decrease or increase in your weight in past six months</u>** **Yes / No**

(C) Have you visited a doctor /hospital /healthcare unit for evaluation or treatment in recent past if yes, give details: _____
_____
_____

Give Details of hospitalization (Attach Copy of discharge card and doctors consultation notes and investigations copy): _____
_____
_____
_____

Past surgical details: Name of surgery or 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 benefit under this Mediclaim policy.

Name of applicant _____Signature:

Date: Place: