

## **Bajaj Allianz General Insurance Company Limited**

Regd. & Head Office: GE Plaza, Airport Road, Yerwada, Pune - 411006.

For Office Use Only: For Agent Use Only:

Scrutiny No.	Receipt No.	Policy No.	Loan Account Number	IMD Code	Sub IMD Code	IMD Name	Mobile No.	Emp/LG Code

## **CRITICAL ILLNESS - PROPOSAL FORM**

## Instructions For Filling Up The Form:-

- 1. Please answer all questions in BLOCK letters
- $2. \ \ The \ Liability of the \ Company does not commence until this Proposal has been accepted by the \ Company and premium has been paid$

Proposer Details	ıy and all a																														
1) Full Name: Title															First	t Nar	ne													Ι	
Middle	e Name														Surr	name	е		Ī	İ								Ī			Ī
<ol><li>Are you an existing</li></ol>	Bajaj Al	lianz	Cust	ome	er: Ye	s / N	lo I	If yes	s, ple	ease	men	tion	the	Policy	No: O	)G _															
3) Gender: Male	Femal	e [	7 (	Othe	er 🗀	1									1) Dat	e of	Birth	:	D			M	M			Υ	Υ	Υ			
5) PAN No.	_ 		_ 	- 1	Ī										5) UID	)/Un	ique l	ı : DD	1	1			-	] 		1	Ι		1	I	1
اــــــــــــــــــــــــــــــــــــ	ee Code,	, if Pr	opos	er is	BAG	IC/B	ALIC	Emp	loye	ee:									L		!										
8) Marital Status:	Marrie	ed	S	ingle		] Div	orce	d		] Wi	dowe	ed	•		9) No.	of C	hildr	en		S	ions	, [				Da	ught	ers			
10) Occupation :	Busine	ess		Sala	ried		Prof	fessio	onal		Stud	dent		Hou	se Wi	fe		Reti	ired	I		Ot	hers	 ;							
11a) Permanent / Res	idential /	Addr	ess :																												
House No & Name																															
Landmark/Locality																															
Road/Area Name															City																
State																							Pi	n Co	de						
11b) Correspondence	Address	: (Al	l the	com	mun	icati	ons	will b	be s	ent 1	to the	bel	ow a	ddres	s) _	1										1					
House No & Name																															$\perp$
Landmark/Locality																															$\perp$
Road/Area Name															City																
State						ĺ																	Pi	n Co	de		Ī		Ì	ĺ	Ī
Telephone (Res.)						Ī								Telepl	one (	Offic	ce)			ĺ							Ī			Ī	Ī
Mobile Number										Е	-Mail												(	<u> </u>							
12) Educational Qualif	ication:		Matri	cula	te	(	Jnde	er Gr	adu	ate		Grad	uate	: 🗌	Post G	Gradi	uate		Pro	fess	sion	ally	Qua	lifie	k						
13) Family Monthly In			Up to				_	-			to Rs.	50,	000		Rs.	50,0	01 to	Rs.	1 la	kh			Abo	ve R	s. 1	lakh	ı	1	1		1
14) In case of any Offe	er, you w	ould	pref	er to	be c	onta	ctec	by:	Ш	Pho	one		Em	ail	15) Na	atior	ality														$\perp$
Section-II Insurance	ce Infor	mat	ion																												
Critical Illness benefit	applied t	for R	s									_																			
Do you have other cur			_			ess I	nsur	rance	e wit	th B	AGICL	. ?																Ш	Yes	Ш	No
If yes Policy No. ——								-				_		_																	
Do you have other cur If ves:			Ü										•	,														Ш	Yes	Ш	No
Name of Institution:																	_				Yea		D	Ь	7 [	NA	NA	V	/		
Has any proposal for L																			_		166	11			_  L	1 V I	1 1 1			1.	
Insurance on your life	•		-		•						•				atcu													П	Yes	П	No
If yes, give details incl		•			•						•																				
Section-III Health																															
PLEASE ANSWER ALL C	QUESTIO	NS B	ү сн	ECKI	NG I	ITHE	RTI	HE YI	ES O	RNO	) ВОХ	(																			
. Are you now in goo	od health	n and	entii	rely f	ree f	rom	anyı	ment	tal o	r ph	ysical	imp	airm	ents o	defo	rmit	ies?												Yes		No
2. Height	(Cm	.) '	Weig	ht			(	Kg.)	Ho	w m	uch w	eigh	ıt hav	ve you	lost o	r gair	ned o	vert	he	last	12 ו	mon	ths?	,			(Kg.	)			
Reason for weight																											., 0				
VEG2011101 MEISTI																															

Yes No

a) Diseases of the circulatory system

 $(e.g.\ heart\ trouble, chest\ pain, rheumatic\ fever, high\ blood\ pressure, diseases\ of\ the\ arteries\ and\ veins)?$ 

IMD Code: 10000006
1
www.insureatclick.com
ownloaded from

	b)	$Diseases of the {\it respiratory system (e.g. tuber culosis, as thma, persistent cough, pneumonia or emphysical contents of the {\it respiratory system (e.g. tuber culosis, as thma, persistent cough, pneumonia or emphysical cough)}. \\$	ema)?	Yes No								
	c)	Diseases of the genito-urinary  system  (e.g.  in fections  of the  kidneys,  urinary  or  genital  organs,  renal  stock of the  kidneys  and  because  and  and  because  and  because  and  because  and  because	nes, venereal disease)?	Yes No								
	d)	$Diseases of the \ gastroint estinal \ system \ (e.g.\ digestive\ disorders, \ gastric\ or\ duodenal\ ulcer,\ hepatitis\ B,\ bother\ disorders\ of\ the\ liver,\ disorders\ of\ the\ gall\ bladder)?$	nepatitis C or	Yes No								
	e)	Diseases of the nervous system or mental disorders (e.g. stroke, epilepsy, fits or fainting attacks, frequenervous breakdown, depression or other mental or psychiatric disorder)?	nt headaches,	Yes No								
	f)	Diabetes mellitus, cancer or tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes	orskin?	Yes No								
	g)	$Un explained \ night-sweats \ and/or \ loss \ of \ weight, per sistent \ fever, chronic \ or \ recurrent \ diarrhea, unexpor swollen \ glands?$	ained infections	Yes No								
	h)	Any other diseases or ailments not mentioned above?										
4.		e you or any of your immediate family members (father, mother, brother, or sister) have/had cancer, heake and at what age? Prior to age 60?	art attack, or	Yes No								
5.	Hav	e you ever had or been advised to have hospital treatment or surgery?		Yes No								
6.		e you ever had or been advised to have a blood test for AIDS or an AIDS-related condition or have you eve blood donor?	er been refused	Yes No								
7.		e past 5 years, have you consulted a physician for any reason or have you had any investigation such as bys, electrocardiograms, ultra sonograms, CT scans or biopsy, other than for routine employment or imm	-	Yes No								
8.	Hav	e you ever received or do you now receive any personal accident, disability benefit, or disability-related	payments?	Yes No								
9.	Are	you at present or any time in past were on any medication, special diet, or treatment?		Yes No								
10.		e you ever taken narcotics or other habit forming drugs or been treated or advised in connection with your alcohol consumption he taking of drugs?										
11.		ou participate or do you intend to participate in any hazardous sports or activities such as motor sports, g-gliding, or aviation except as a fare-paying passenger?	climbing, parachuting,	Yes No								
12.		you pregnant (for female only)? If yes, please state how many months. Please state if you had any pregn plication during your previous pregnancy/delivery?	ancy related	Yes No								
13.		e you smoked or used any substance or product containing tobacco, nicotine or marijuana? s, please state duration and average daily consumption and type:		Yes No								
14.	Nan	ne and address of your regular medical consultant:										
,		swered "yes" to any of the questions numbered 1 to 13 (in Section 3 Health Status), please give com nd addresses of physicians) on the reverse of this form and include your signature and the date.	plete details (including dates, dura	ation and treatment,								
Se	ectio	n-IV Declaration										
	truction I/W has I/W insusee und	We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above so and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose derstand that the information provided by me will form the basis of the insurance policy, is subject to the pany and that the policy will come into force only after full receipt of the premium chargeable. The full receipt of the premium chargeable and that I/we will notify in writing any change occurring in the occupation or general heal been submitted but before communication of the risk acceptance by the company. The declare and consent to the company seeking medical information from any doctor or from a houred/proposer or from any past or present employer concerning anything which affects the physical or king information from any insurance company to which an application for insurance on the life to be derwriting the proposal and/or claim settlement.  The authorize the company to share information pertaining to my proposal including the medical record ms settlement and with any Governmental and/or Regulatory authority."	on behalf of these other persons. The Board approved underwriting point of the life to be insured/proposes spital who at anytime has attended in mental health of the life to be as assured/proposer has been made	er after the proposal led on the life to be sured/proposer and e for the purpose of								
			Signature of Propos	er								
Nar	ne a	nd Designation:	·									

INSURANCE ACT 1938 SECTION 41 – Prohibition of Rebates. 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 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 THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO FIVE HUNDRED RUPEES.