Application Number

Please paste the photographs in sequence [Insured Person 1, Insured Person 2, Insured Person 3, Insured Person 4, Insured Person 5, Insured Person 6] as specified in section 3 of details of persons proposed to be insured

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6

Nominee Details

In the event of the death of the Proposer any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer.

Nominee Name	Relationship	Address of the Nominee

* If the Nominee is minor, please give the name and Address of Appointeeee and Relationship with the Minor:

Appointee Name	Relationship	Address of the Appointee

Existing/previous Insurance Details

Is the proposer or any of the persons proposed, already Insured under a plan with Tata-AIG General Insurance Company Limited or any other insurer or is a proposal pending for Policy issuance? If yes, please indicate below the Policy/ Application number(s) (Please mention application number in case of pending proposal.)
Since when are continuously insured:
Do you want Us to consider these details for portability*? Yes No

Policy No. / Application No.	Insurer	Period of Insurance		Sum Insured (Rs)	Claims lodged during the preceding years
		From	To		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		
		DD/MM/YYYY	DD/MM/YYYY		

* Please note that continuity of benefits shall NOT be considered if the details are not provided. You need to approach at least 45 days prior to your expiry date to avoid any break in coverage.

Medical And Lifestyle Information

Important : You must answer the following questions truthfully. Not doing so affects your coverage in case of a Claim
Medical History: Please answer the below mentioned questions in Yes (Y) / No (N)

Section A: Have any of the persons proposed to be insured ever suffered from/currently suffering from any of the following :	**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**
i. Hypertension, chest pain, Ischemic heart disease or any other cardiac disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
ii. Tuberculosis, asthma, bronchitis or any other lung/respiratory disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
iii. Ulcer(stomach/duodenal), hepatitis, cirrhosis or any other digestive or liver/ gallbladder disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
iv. Renal failure, calculus or any other kidney/ urinary tract or prostate disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
v. Dizziness, stroke, epilepsy, paralysis or other brain/ nervous system disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
vi. Diabetes, thyroid disorder or any other endocrine disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
vii. Tumor-benign or malignant, any ulcer/ growth/cyst	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
viii. Arthritis, spondylosis or any other disorder of the muscle/bone/joint	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
ix. Diseases of the nose/ear/throat/teeth/ eye (please mention dioptres)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
x. HIV/AIDS or sexually transmitted diseases or any immune system disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
xi. Anaemia, leukaemia or any other blood/ lymphatic system disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
xii. Psychiatric/mental illnesses or sleep disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
xiii. DUB, fibroid, cyst/fibroadenoma or any other gynecological/breast disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Application Number

Section B: Have any of the persons proposed to be insured:	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
xiv. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
xv. Been under any regular medication (self/ prescribed)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
xvi. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
xvii. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
xviii. Suffered from any other disease/illness/ accident/injury	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
xix. Is any of the insured persons pregnant? If yes please mention the expected date of delivery	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
xx. Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Section C: Name and details of Illness/ Medicine/ Test/ Surgery/Diopter grade (for questions answered as Yes in Section A & B)	Diagnosis date	Date of last consultation	Treatment in/ outpatient	Doctor/Hospital Name and Phone No.
Insured 1				
Insured 2				
Insured 3				
Insured 4				
Insured 5				
Insured 6				

Section D: Name, address, qualification and contact details of the family doctor, if any

Name:

Qualification:

Address:

Pin Code

Mobile No: Phone No:

Email ID:

Section E: Does any person proposed to be insured smoke or consume gutkha/pan masala or alcohol. If yes please indicate the name and quantity per week.	Alcohol	Smoke	Pan Masala	Others
Insured 1				
Insured 2				
Insured 3				
Insured 4				
Insured 5				
Insured 6				

Section F: In respect of any of the persons proposed to be insured:	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Has any application for life, health or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Payment Details

Name of the Premium Payer :

Amount (in Rs) _____ Instrument type : Cash Cheque Debit card Credit Card Others _____

Sources of funds : Salary Business Other _____ (Please tick where applicable)

Instrument Type	Instrument Number	Instrument Date	Name of the Payer	Bank Details

Please make a Crossed Cheque/DD/Pay Order in favour of 'Tata AIG General Insurance Company Limited' only.

Application Number

I. Section 41 of Insurance Act 1938 (Prohibition of Rebates) :

(1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take 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 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 prospectus or tables of the insurers.

(2) Any person making default in complying with the provision of this section shall be punishable with fine which may extend to five hundred rupees.

II. AML guidelines :

(1) I/we hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act, 2002.

(2) I understand that the Company has the right to call for documents to establish sources of funds.

(3) The insurance company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statues, directly or indirectly governing the prevention of money laundering in India.

- **Nationality :** Indian ☐ Non-Indian ☐ If Non-Indian, please specify Country : _____

- **Type of Organization**

Corporations ☐ Governments ☐ Non Governmental Organizations ☐ Society ☐

Trust ☐ Partnership ☐ International Organization ☐ Cooperatives ☐ Section 25 Company ☐

PAN Card No. ☐☐☐☐☐☐☐☐☐☐ in the absence of PAN Card, please give details of any other authorized photo identification card.

Card Type _____ Number : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Sources of funds (please where applicable) Salary ☐ Business ☐ Other (Please specify) _____

Additional Information

(If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

General Exclusions

I have carefully read and understood the below mentioned exclusions.

Signature of the proposer _____

The following is an outline of the general exclusions under the policy. For more details on the exclusions and the waiting periods please refer to the policy wordings before purchasing this policy.

30 days waiting period in the first year and is not applicable in subsequent renewals; 2 years waiting period for the specified illnesses/ surgeries. 4 years waiting period for Pre-existing conditions.

War or any act of war, invasion, act of foreign enemy, war like operations, nuclear weapons/materials radiation of any kind; committing or attempting to commit a breach of law with criminal intent, or intentional self injury or attempted suicide while sane or insane; participation or involvement in naval, military or air force operation or any hazardous or dangerous or adventurous activities including but not limited to racing, driving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing; abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services or supplies; treatment of obesity or any weight control program; psychiatric, mental disorders, Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), congenital internal or external diseases, genetic disorders, stem cell implantation or surgery or growth hormone therapy; sleep apnoea; venereal disease, sexually transmitted disease, "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus)' sterility / infertility treatment of any type; pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy; treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, muscle stimulation by any means except for treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities; dental treatment unless requiring hospitalization; treatment of nasal concha resection, circumcisions unless necessitated by illness or injury and forming part of treatment, laser treatment for correction of eye due to refractive error, aesthetic or change-of-life treatments; plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment for reconstruction following an Accident, Cancer or Burns; experimental, investigational or unproven treatment devices and pharmacological regimens; measures primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the diagnosis and treatment; convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care; all preventive care, vaccination including inoculation and immunizations (except in case of post- bite treatment); any non allopathic treatment; enteral feedings and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim; charges related to a Hospital stay not expressively mentioned as being covered, items of personal comfort and convenience, vitamins and tonics; treatments rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who shares the same residence as an Insured Person or who is a member of an Insured Person's family; the provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products; any treatment or part of treatment that is not of a reasonable cost, not medically necessary; drugs or treatment which are not supported by a prescription; artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment. Any specific timebound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the Insured, as per Our underwriting guidelines , any non medical exclusions as per Annexure II of the policy document

Please cut here

Application Number

Bank Detail (Required for Refunds if any Claims)

Would you like your refund (Excess Premium/) ☐ By Cheque* or ☐ Credited directly into your bank account. (Tick as applicable)* Cheque will be issued in the name of the Proposer only.

In case of payment made through credit card the refund amount would be reversed in Credit Card account directly or through cheque.

Cheque ☐ Credit Card ☐

Please provide the following bank details and a copy of a Cancelled Cheque if you opt for direct credit into your bank account: (Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly)

Name as in Bank A/c : _____

Bank Name & Branch : _____

MICR Code : _____ IFSC Code : _____

Note: The Proposer agrees and undertakes to intimate in writing to Tata AIG General Insurance Company Ltd. about any change in bank account details.

Signature Proposer: _____ Date: D D M M Y Y Y Y

Co-insurance Option

☐ I agree to exercise Co-insurance option with Tata AIG General Insurance Company Ltd. (Lead insurer) and Apollo Munich Health Insurance Company Ltd (Co-Insurer).

☐ I do not require a Co-insurance option

☐ I agree to exercise Co-insurance option with Tata AIG General Insurance Company Ltd. (Lead insurer) and _____ (Co-Insurer).

Notwithstanding the role and liability of the Co-Insurer in terms of the above Co-Insurance arrangement, for the avoidance of doubt, it is hereby declared that under the above co-insurance arrangement the Lead Insurer is the Insurer for all Policy purposes including but not limited to the collection of premium, policy administration, notices, policy and claims decisions, and the payment of claims.

DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- I/ We 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.
- I understand that the information provided by me will form the basis of 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.
- I/ We 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.
- I/We declare and consent to the company seeking medical information from any 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 and 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.
- I/ We 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.

Signature of the Proposer: _____

Place: _____ Date: D D M M Y Y Y Y

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 the 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 the Proposer _____ Signature of the witness _____

Date: D D M M Y Y Y Y Name of the witness: _____

Place: _____

INSURANCE IS THE SUBJECT MATTER OF SOLICITATION

Agent's Declaration

I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal 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, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour 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. (Advisor/Corporate Agent/Broker/Relationship Officer)

Place: _____

Date: D D M M Y Y Y Y Signature of Agent: _____

Application Number

Check List

Please check the following documents are attached along with the proposal form

1. ID Proof: Passport/ PAN Card/ Voter ID/ Driving License/ Letter from a recognized public authority
2. Proof of residence: Telephone Bill/Bank Account Statement/Letter from any recognized public authority/ Electricity Bill/ Ration Card
3. Age Proof: Proof of Age
4. Renewal Notice with claim details
5. Certification of previous insurer for previous claim details
6. Photocopies of all previous policies and endorsements

For Office Use Only

Tata-AIG Office Code: _____ **Advisor Code and Name:** _____

Branch Receipt Date: _____ **Channel Type:** _____

Business Type: Urban/ Rural/ Social

Insurance is the subject matter of the solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale. Tata AIG General Insurance Company Ltd.

Tata AIG General Insurance Company Ltd.

Registered Office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Lower Parel, Mumbai- 400013.
IRDA Registration Number: 108 CIN: U85110MH2000PLC128425 Toll Free Helpline No. 1800 266 7780. Website : www.tataaiginsurance.in

Please cut here

Application Number: _____ Date: _____

Name of the Proposer _____

We acknowledge with thanks the receipt of your application and amount by cash/cheque/Demand Draft/others _____ _____ of amount of Rs. _____.

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions and we shall have no liability to make any payment if proposal is not accepted by us or you do not accept the terms of counter offer or premium is not received by us in full and in time, or is not realised, or non-fulfillments of Pre Policy Checkup and/or additional information requested by us. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 7 days subject to deduction of the Pre Policy Check up charges, as applicable. In case of counter offer you need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 15 days, we shall cancel application and refund the premium paid without interest within next 7 days subject to deduction of the Pre Policy Check up charges, as applicable.

Signature of the receiver and office seal _____

Place: _____

Date | | | | | | | | |