

Empower Health Plan, Niva Bupa Health Insurance Co. Ltd. - Proposal Form

URN: 027



1. Proposer details:

Title _____ Name _____ Date of Birth _____ Gender: Male Female Other
 Current address _____

City _____
 State _____ Pin code _____

Mobile number _____
 Email ID _____ PAN Number _____

Nationality _____ Annual income (Rs) _____

Occupation: Salaried Self-employed Student Housewife Other, please specify _____

Do you want the Physical Copy of the Policy Kit: Yes No

Health Care Worker*: Yes No (* Avail a discount of 5% on the premium.)

Premium paid by _____ Relationship with Proposer _____

- I wish to receive my policy related information and updates over WhatsApp on my mobile number.
 I have read, understood and accepted all Terms and Conditions & hereby authorize Niva Bupa Health Insurance or any of its Agents and/or third party(ies)/ affiliates to contact me via SMS/Email/Phone/WhatsApp/Facebook or any other modes on my registered phone number over-riding my 'DND' registration to make welcome calls/SMS, service calls/SMS or any other commercial communication

Are you or any of the proposed applicants a PEP**? Yes No

***Politically Exposed Persons (PEP) are individuals who are or have been entrusted with prominent public functions i.e. Heads / ministers of central or state government, senior politicians, senior government, judicial or military officials, senior executives of government companies, important party officials. (If you have ticked against PEP, kindly fill the separate PEP questionnaire)*

Bank details:

Bank name _____ Branch _____ City _____
 Account number _____ IFSC Code _____ Account type: Savings Current

Details of Electronic Insurance Account (eIA)

Do you wish to have this Policy credited to an e-Insurance account? (Please select any one)

No I do not have an e-insurance account and do not wish to open one

Yes Credit this Policy to my e-Insurance account

If yes, Please share existing E-Insurance Account No.

Please select Insurance Repository Name (you have opened your account with)

1. M/s NSDL Database Management Limited 2. M/s Central Insurance Repository Limited
 3. M/s Karvy Insurance Repository Limited 4. M/s CAMS Repository Services Limited (Please select any one) Or

I do not have existing e-Insurance account and I am interested in creating a new e-Insurance account

(Please submit electronic insurance account opening form (eIA form) along with relevant documents).

2. Coverage selection:

Base coverage:	
Policy type:	<input type="checkbox"/> Individual
Base Sum Insured:	<input type="checkbox"/> INR 4,00,000 <input type="checkbox"/> INR 5,00,000
Policy term:	1 Year

3. Details of applicants for insurance:

Applicant Number	Name	Gender (Male/Female/Other)	Date of birth (dd/mm/yyyy)	Relationship	Please tick if not Indian
1				Self	<input type="checkbox"/>

4. Nomination

In the event of the death of the Proposer, any payment due under the Policy shall become payable to the Nominee named below. The receipt of such payment by the Nominee would constitute discharge of the Company's liability under the Policy. Nominee for all other applicant(s) shall be the proposer himself/herself.

Nominee Name	Date of Birth	Relationship with the Proposer	Address, mobile number and email ID of Nominee	Appointee Name (if nominee is less than 18 years of age)

Bank details of Nominee: Beneficiary Name: _____

Bank name _____ Account type Savings Current

Account number _____ IFSC Code _____

5. Medical, habits and past proposal information

IMPORTANT: Please ensure that all the questions in this section are answered truthfully and completely as the information You provide here will form basis of underwriting by Niva Bupa. Please note any incomplete, incorrect, partially correct information may affect your medical claim and/or coverage.

Please answer the following questions for the Main Applicant		Applicant	
Please circle Yes (Y) or No (N)			
1	Has any applicant been diagnosed with any of the following disabilities/diseases (if yes, please provide details)		
a.	Blindness	Y	N
b.	Muscular Dystrophy	Y	N
c.	Low Vision	Y	N
d.	chronic neurological disorder	Y	N
e.	Leprosy cured person	Y	N
f.	Specific Learning disabilities	Y	N
g.	Hearing impairment (deaf and hard of hearing)	Y	N
h.	Multiple sclerosis	Y	N
i.	Locomotor Disability	Y	N
j.	Speech and language disability	Y	N
k.	Dawrfism	Y	N
l.	Thalassemia	Y	N
m.	Intellectual Disability	Y	N
n.	Haemophilia	Y	N
o.	Mental Illness	Y	N
p.	Sickle Cell Disease	Y	N
q.	Autism Spectrum Disorder	Y	N
r.	Multiple Disability Including deaf and blindness	Y	N
s.	Cerebral Palsy	Y	N
t.	Acid Attack Victim	Y	N
u.	Parkinson	Y	N
2	Other than common cold, flu, infections, minor injury or other minor ailments; has the Applicant ever been diagnosed with any disease and / or hospitalized for more than 5 days and / or undergone / advised to undergo any surgical procedures and / or taken any medication/ had any symptoms for more than 14 days? Medication is including but not limited to inhalers, injections, oral drugs and external medical applications on body parts.	Y	N
3	Has the Applicant ever had adverse findings to any diagnostic tests or investigations related to Thyroid Profile, Lipid Profile, Treadmill test, Angiography, Echocardiography, Endoscopy, Ultrasound, CT Scan, MRI, Biopsy and FNAC?	Y	N
4	Does the Applicant have diabetes or pre-diabetes or has he/she EVER had high blood sugar?	Y	N
5	Does the Applicant have Hypertension or High Blood Pressure?	Y	N
6	Has the Applicant ever been diagnosed or treated for any genetic / hereditary disorders or HIV / AIDS?	Y	N
7	Has any proposal for life, health, hospital daily cash or critical illness insurance on the life of the Applicant ever been declined, postponed, loaded or subjected to any special conditions such as exclusions by any insurance company?	Y	N

6. Authorization for electronic Policy fulfillment and service communications

Would you like to protect the environment and help save paper by authorizing the Company to send all your Policy and service related communication to the email ID as mentioned here in the application form? Yes No

7. Declaration (Please read carefully and put a check mark against each before signing the proposal form)

__ 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.

__ 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 insurer and that the Policy will come into force only after full payment of the premium chargeable.

__ 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.

__ I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

__ I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.

__ I/We authorize the Company to share information pertaining to my / our proposal including the medical records of the Insured / Proposer for the sole purpose of Service Delivery with our empaneled provider.

Dated __/__/____ Place _____ Signature of the Proposer _____

8. Vernacular declaration

(Certification in case the Proposer has signed in vernacular (to be witnessed by someone other than agent/ employee of the Company)).

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:

Name of the certifying person: _____ Signature of the certifying person: _____ Mobile number of the certifying person: _____

Name of the Witness: _____ Signature of the Witness _____ Mobile number of the witness: _____ Signature of the Proposer _____

9. Proposer declaration

(Certification where for any reason, the proposal and other connected papers are not filled in by the Proposer).

The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract. The Proposal Form is filled by _____ under my instruction and I found it to be correct.

Signature of the Proposer _____

10. Details for Refund & Payment of Claims

Option to receive payment: Bank Transfer

Name of the Beneficiary: _____

Bank Name: _____ IFSC Code: _____

Account Number: _____

Account Type: _____

11. Premium details (for office use only)

Premium payment option Cheque Demand Draft Credit card Cash Other Premium amount _____

Online payment transaction ID: _____ Date: __/__/____ Bank name/ branch _____

Niva Bupa branch location _____ Code No _____ Business sourced by: Advisor/DST/Corporate agency/ other channels

Code No _____ Name _____ Proposal received on: _____ Customer ID: _____

Is Proposer or the applicant a staff? Yes No

12. Additional details for Bancassurance channel only (for office use only)

Branch Code _____ SP Code _____ RM/LG code _____

Customer account number _____

13. Insurance advisor's report (for office use only)

I, in my capacity as an Insurance Advisor / Specified Person of the Corporate Agent / Authorised 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 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.

Date / /

Signature of the Insurance Advisor _____

(Note – The details provided under Section 10, 11 and 12 are for office use only and are not to be filled by the Proposer. Therefore, these sections are indicative as they do not have any relation with the details filled by Proposer. This note won't appear in the proposal form sent to the customers and is a part of file & use approval only)

14. ABHA ID

Member Name	Do you have ABHA ID?	ABHA ID	Consent to share Medical records with insurers/TPA's through ABHA
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

15. Statutory Warning

Prohibition of Rebates (Under Section 41 of the Insurance Act 1938)

- 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 prospectuses or tables of the insurer.
- 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.

Niva Bupa Health Insurance Company Limited; Registered office:- C-98, First Floor, Lajpat Nagar, Part 1, New Delhi-110024 Disclaimer: Insurance is a subject matter of solicitation. Niva Bupa Health Insurance Company Limited (formerly known as Max Bupa Health Insurance Company Limited) (IRDAI Registration No. 145). 'Bupa' and 'HEARTBEAT' logo are registered trademarks of their respective owners and are being used by Niva Bupa Health Insurance Company Limited under license. Customer Helpline: 1860-500- 8888. Website: www.nivabupa.com. CIN: U66000DL2008PLC182918. For more details on terms and conditions, exclusions, risk factors, waiting period & benefits, please read sales brochure carefully before concluding a sale.

Product Name: Empower Health Plan, Niva Bupa Health Insurance Pvt. Ltd. | UIN : NBHHLIP23193V012223

Acknowledgment by the Company

Application No. _____

Date / /

We acknowledge with thanks the receipt of your proposal and amount by Cheque/Demand Draft/ Others-----of amount of Rs. -----
 ----- dated -----drawn on-----

Neither the submission to us of a completed proposal for Insurance nor any payment made towards issuance of a Policy 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's terms and conditions and we shall have no liability whatsoever if premium is not received by us in full and in time or is not realized. If we do not accept the proposal, we will inform you and refund the payment after deducting cost of medical tests, if any, received from you without interest.

Name and Signature of the receiver and office seal