Everyday Health Proposal Form

Proposal Form Filling Instruction

1, Kindly fill in the form in CAPITAL LETTERS only. 2. Please select the option by ticking the relevant box in the Proposal Form. 3. This proposal form is to be filled, dated, signed and sealed in by the Proposer/ its authorized representative only. 4. It is essential to provide all information / details asked in this proposal form. All questions are required to be answered fully and correctly. 5. Please use additional sheet in case the space in the proposal form is not sufficient to fill in the details. 6. Please strike off whichever is not opted.

1. Proposer details:

Name of Proposer:

Proposer's Trade/ Business:

Key Contact Person:

Designation:

Address for Correspondence:

Landmark City

District State Pincode

Landline No.: Mobile No:

Email ID Alternate No:

PAN No:

GST No:

CKYC No:

Do You want Physical Copy of the Policy Kit? Yes No

2. Coverage details:

Proposed Policy Start Date D D M M Y Y Y Y Proposed Policy End Date (Midnight) D D M M Y Y Y Y

Number of persons to be insured

Categories of proposed insured (Add more categories if needed) – brief description for e.g. senior management, middle management

1. Category 1
2. Category 2
3. Category 3
4. Category 4
5. Category 5

Is selection of coverage involved Is the premium paid by the member

Premium Payment Frequency _____ Free look period _____

Please provide the details of benefits opted for all members: (All Sections are optional. Please select only the required section)

	Category 1	Category 2	Category 3	Category 4	Category 5
Number of proposed insured					
Benefits					
Video Consultations with General Practitioner					
Tele Consultations with General Practitioner					
Physical Consultations with General Practitioner					
Video Consultations with specialists					
Tele Consultations with specialists					
Physical Consultations with specialists					
Diagnostic Services					
Pharmacy Services					
Home Health Care Services					
Vaccination Cover					
Annual Health Check-up					
Second Medical Opinion					
Wallet					
Vouchers					
Monitoring / Medical Devices					
Wellness Benefits					
Condition Management Packages					

3. Details of Insured Person:

Member's Unique ID	Names of the Insured	Date of Birth or Age	Gender	Base Sum Insured	Nominee/ Appointee Name (if nominee is less than 18 years of age) Details		Permanent exclusions
					Address, mobile number email ID of Nominee	Relation with Insured Person	

Any additional information material to assumption of risk: _____

_____

_____

4. Past Insurance Policy Details (up to last 3 years if applicable)

Policy Period From – To	Name of the Insurer	Policy number	Number of members covered	Total premium (Rs.)	Total amount of claims (Paid + Outstanding) (Rs.)

5. Declaration

- ☐ 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/us are true and complete in all respects to the best of my/our knowledge and that I/We am/are authorized to propose on behalf of these other persons.
- ☐ I/We understand that the information provided by me/us 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 further consent to the Company seeking medical information from any doctor or hospital who/which at anytime 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/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 underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory Authority and/or our empaneled provider.

Date D D M M Y Y Y Y

Place

Signature of the Proposer

6. Proposer 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 Witness

Signature of the Witness

Signature of the Proposer

7. Statutory Warning

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

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 prospectuses or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be punishable with fine 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

8. Acknowledgement

Application No. Date D D M M Y Y Y Y

We acknowledge with thanks the receipt of your proposal and amount by Cash/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 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 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, if any, received from you without interest.

Name and signature of the receiver and office seal