Health Plus - Proposal Form

niva Bupa Health Insurance

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 authorised 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's details:

Name of Proposer

Proposer's Trade/Business

Key Contact Person | Designation

Address for Correspondence

City | District

State

Mobile No. | Alternate Number | Pin-code

Email ID

PAN No. | GST No.

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

2. Coverage details:

I. Policy Period:

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)

II. Number of persons to be insured

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

1. Cat 1
2. Cat 2
3. Cat 3
4. Cat 4
5. Cat 5

IV. Is selection of coverage involved | **V. Is the premium paid by the member**

VI. Premium Payment Frequency

VII. Free look period

VIII. Please provide the details of benefits opted for all members:

(All Sections are optional. Please select only the required section)

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Number of proposed insured					

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Section 1: Hospitalization Cover					
Base Sum Insured					
Plan – (*Individual/Floater/Combination)*					
Relationships covered if Floater opted					
Hospital Accommodation (Room Rent/day) – *Please choose the option and specify % or value or category as applicable*					
Hospital accommodation (ICU/day) – *Please specify the option A/option B*					
Pre hospitalization Medical Expenses – *Please specify no of days*					
Post hospitalization Medical Expenses – *Please specify no of days*					
Inpatient Care under Alternative Treatment - *Please specify % of Base Sum Insured*					
Domiciliary Hospitalization - *Please specify the limit*					
Organ Transplant - *Please specify **'Yes' /'No'***					
Modern Treatments - *Please specify **'Yes' /'No'** and limits*					
Maternity Expenses – *Please specify limit for Normal & Caesarean*					
Maternity Expenses – *Waiting Period (in months)*					
New Born Baby Cover – *Please specify % of Base Sum Insured (Hospitalization Cover) or Maternity Expenses – Caesarean sublimit*					
New Born Vaccination Cover – *Please specify % of Maternity Expenses Caesarean sub-limit*					
Pre and post natal expenses – *Please specify limit*					
Cord blood banking cost cover - *Please specify limit*					
Emergency Ground Ambulance - Within India *Please specify limit for Non-network hospitals*					
Air Ambulance Cover - Within India - *Please specify limit*					
Prosthetics Cover – *Please specify Option I/Option II*					
Compassionate visit - *Please specify limit*					
Accompanying person accommodation cover – Please specify % of Base Sum Insured (BSI) & Deductible (Days)	% - Deductible -	% - Deductible -	% - Deductible -	% - Deductible -	% - Deductible -
Health Check-up – *Please specify limit(per member/family), option & check-up frequency*					
Sub-limit on specified illness/conditions – *Please specify Illness & option selected*					
Loyalty Credit – *Please specify opted %*					
No Claim Bonus – *Please specify opted %*					
Re-fill Benefit - *Please specify* **'Yes' /'No'**					
Co-payment (all members) – *Please specify %*					
Co-payment (for members older than specified age) – *Please specify age & %*	Age – % -	Age – % -	Age – % -	Age – % -	Age – % -
Co-payment (for relationships) – *Please specify relationship & %*	Relationships _____ _____ % -	Relationships _____ _____ % -	Relationships _____ _____ % -	Relationships _____ _____ % -	Relationships _____ _____ % -
Co-payment (for certain benefit options only) – *Please specify benefits & %*	Benefits _____ _____ % -	Benefits _____ _____ % -	Benefits _____ _____ % -	Benefits _____ _____ % -	Benefits _____ _____ % -
Annual Aggregate Deductible – *Please specify Deductible*					
Annual Catastrophic Claim Deductible - *Please specify Deductible*					

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
e-Consultation - *Please specify* **'Yes' /'No'**					
Inclusion of Cyberknife/ Robotic surgery - *Please specify* **'Yes'/'No'**					
Corporate Floater for any Illness or Accident – *Please select option* *Option A: Please specify % of Base Sum Insured & Corporate Floater limit* *Option B: Please specify Corporate Floater limit*					
Corporate Floater for 11 listed Critical Illness - *Please select option* *Option A: Please specify % of Base Sum Insured & Corporate Floater limit* *Option B: Please specify Corporate Floater limit*					
Claim Settlement in Network only - *Please specify* **'Yes'/'No'**					
Claim settlement on Reimbursement Only - *Please specify* **'Yes'/'No'**					
Restriction of cashless treatment in Specified Provider Network - *Please specify* **'Yes' /'No'** *If 'Yes' please specify List of Network Hospitals % of Co-payment for treatment in Non-Network Provider*					
Home Health Care Services - Please specify 'Yes'/'No'					
Waiting Periods					
Waiting period for Pre-Existing Diseases (PED) – *Please specify period in months*					
Initial Waiting Period - *Please specify period in days*					
Waiting Period for Disease Specific Exclusions - *Please specify period in months*					

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Section 2 - Fixed Benefit coverage for named Illness					
Number of proposed insured					
Relationships covered					
Please specify Sum Insured					
Please specify the option for which coverage is required					
Waiting Periods					
Waiting period for Pre-Existing Diseases (PED) - *Please specify period in months*					
Initial Waiting Period - *Please specify period in days*					
Waiting Period for Disease Specific Exclusions - *Please specify period in months*					

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Section 3–Hospital Cash Benefit (Per Member)					
Number of proposed insured					
Relationships Covered					
Daily Cash Benefit - *Please specify*					
- Limit/day					
ICU Cash Benefit – Please specify 'Yes'/'No'*					
Other Features					
- Number of days of coverage					
- Please specify if Deductible/Franchise opted					
- If 'Yes', please specify the number of days of Deductible/Franchise opted					

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Accidental Hospital Cash Benefit– *Please specify 'Yes'/'No'*					
- Limit/day					
Accidental Hospital ICU Cash Benefit^ – *Please specify 'Yes'/'No'*					
Other Features					
- Number of days of coverage					
- Please specify if Deductible/Franchise opted					
- If 'Yes', please specify the number of days of Deductible/Franchise opted					
Waiting Periods					
Waiting period for Pre-Existing Diseases (PED) - *Please specify period in months*					
Initial Waiting Period - *Please specify period in days*					
Waiting Period for Disease Specific Exclusions - *Please specify period in months*					

* ICU cash benefit will be available only if Daily Cash benefit has been opted without Deductible
^Accidental Hospital ICU cash benefit will be available only if Accidental Hospital Cash benefit has been opted without Deductible

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Section 4 - OPD Treatment					
Number of proposed insured					
Plan (Individual/Floater)					
Relationships covered if Floater opted					
OPD Treatment & Diagnostic Cover – *Please specify options (Consultation, Diagnostic Test, Pharmacy, Procedures), Limit & Co-payment % (if opted)*					
OPD Dental Expenses - *Please specify Limit & Co-payment % (if opted)*					
OPD Vision Expenses - *Please specify Limit, Co-payment % (if opted) and Option*					

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Section 5 - International Coverage					
Number of proposed insured					
Plan (Individual/Floater)					
Relationships covered if Floater opted					
International Coverage Sum Insured					
Emergency Hospitalization - *Please specify limit*					
Specified Illness Cover (9 listed conditions)- *Please specify limit*					
Medical Repatriation - *Please specify limit*					
Repatriation of Mortal Remains - *Please specify limit*					
Geographical Coverage – *Please specify Option A/B/C*					
Waiting Periods					
Waiting period for Pre-Existing Diseases (PED) – *Please specify period in months*					
Initial Waiting Period - *Please specify period in days*					
Waiting Period for Disease Specific Exclusions - *Please specify period in months*					

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Section 6–Accidental Cover					
Number of proposed insured					
Accidental Cover Sum Insured (SI) – Please specify the limit/ member					
Accidental Death - *Please specify 'Yes'/'No'*					
Air Accident Death – *If opted, please specify multiple for Accidental Cover Sum Insured*					
Last rites Expenses – *If opted, please specify limit*					
Common accident – *Please specify 'Yes'/'No'*					
Accidental Permanent Total Disability - *Please specify 'Yes'/'No'*					
Residential or Vehicle Modification allowance – *If opted, please specify limit*					
Accidental Permanent Partial Disability - *Please specify 'Yes'/'No'*					
Temporary Total Disability – *Please specify weekly payout limit*					
Accidental Medical Reimbursement – *Please specify 'Option' & Limit*					
Education Allowance for Children– *Please specify limit*					
Family Transportation allowance - *Please specify limit*					
Broken Bones - *Please specify limit*					
Child Wedding - *Please specify limit*					
Burns - *Please specify limit*					
Medical Insurance Premium Indemnity – *Please specify limit & number of years*					
Air Ambulance for Accidental Injuries – *Please specify limit*					
Comatose Benefit– *Please specify 'Yes'/'No'*					
Outstanding Loan Cover – *Please specify Limit*					
Chauffeur Benefit – *Please specify monthly limit & number of months*					
Reconstructive Surgery – *Please specify limit*					
Physiotherapy charges following accidental injury – *Please specify limit*					

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Section 7–Critical illness Cover					
Number of proposed insured					
Relationships covered					
Critical Illness Sum Insured (SI)/member					
Critical Illness covered – *Please specify option*					
Sum Insured Enhancement – *Please specify % increase p.a*					
Loan Protector – *Please specify limit (% of Critical Illness SI)*					
Income Protector – *Please specify monthly limit & no of months*					
Staggered Payout – *Please specify 'Yes'/'No'*					
Death Benefit – *Please specify limit (% of Critical Illness SI)*					
Second Medical Opinion for Critical Illness – *Please specify 'Yes'/'No'*					

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Waiting Periods					
Waiting period for Pre-Existing Diseases (PED) – *Please specify period in months*					
Initial Waiting Period - *Please specify period in days*					
Survival Period - *Please specify period in months*					

	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5
Section 8–Wellness Benefits					
Number of proposed insured					
Pharmacy Services - *Please specify 'Yes'/'No'*					
Diagnostic centre - *Please specify 'Yes'/'No'*					
OPD Services - *Please specify 'Yes'/'No'*					
Personalized health coaching - *Please specify 'Yes'/'No'*					

IX. Details of Insured Persons: (Please attach a separate sheet if required):

Member's Unique ID	Category	Names of the Insured	Date of Birth or Age	Gender	Relationship with Primary Insured	Designation/ Occupation	Any existing Illness	Nominee/Appointee Name (if nominee is less than 18 years of age) Details	
								Address, mobile number email ID of Nominee	Relation with Insured Person

X. Any additional information material to assumption of risk:

_____

_____

_____

_____

XI. Special Conditions:

i. Entry Age:

ii. Operative Time:

iii. Others

3. 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.)

4. Declaration:

i. 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.
ii. 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.
iii. 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.
iv. 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.
v. 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..

Dated _ _/_ _/_ _ _ _ Place_____ Signature of the Proposer _____

5. Proposer Declaration:

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

6. 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 Witness: _____

Signature of the Witness _____ Signature of the Declarant _____

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.

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Acknowledgement

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.

Signature of the receiver and official seal _____