Oocyte Guard: Proposal Form

URN: 028

Insurance contract is a legal contract too and it's based on TRUST and We TRUST You.
We understand you may not know how relevant is the information on your health and it's impact on your policy. Hence it's very important that you disclose all health information and we would decide how relevant it is (we call it 'material fact').
We would cancel your policy, will not pay any claim, will not refund any premium paid and have right to take all possible legal action against you including for recovery of benefits paid earlier, if correct and complete information is not provided about all members proposed to be insured.
Regulations mandate that the coverage can start only after we have received the full premium and have explicitly accepted the risk.

1. Proposer details:

Proposer: (Mr/Mrs/Ms)	F	I	R	S	T						M	I	D	D	L	E									L	A	S	T					
Date of birth	D	D	M	M	Y	Y	Y	Y			Gender: ☐Male ☐Female ☐ Other																						
Current address:																																	
Land mark:																				City/Town:													
District:																				State:													
Pin Code:																				Mobile:													
Telephone with STD code																				E-mail:													
PAN No (Form 60 if PAN not available)																				Nationality													

ABHA ID: _____
Occupation: ☐ Salaried ☐ Self-employed ☐ Student ☐ Housewife ☐ Other, please specify _____Annual income (Rs)_____
CKYC number (optional): _____

☐ I will do my bit to preserve the planet for children. I will go green. Send me soft copy only. Strictly no paper please

☐ I wish to have this Policy credited to an eIA.
Existing E-Insurance Account No.☐ _____ 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

☐If you wish us to help open an eIA account for you, please fill details in sec 9, NEFT & Bank details Or
☐ I do not have an eIA and do not wish to open one

☐ I 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, policy related information or any other commercial communication.

Are you or any of the proposed applicants a politically exposed person (PEP) ☐ Yes ☐ No
#PEP is someone 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)

Rural & Social Sector Category (if applicable: ☐ ASHA Worker ☐ MGNREGA Worker
Do you want the Physical Copy of the Policy Kit: ☐ Yes ☐ No

2. Details of applicants & plan selection

	Name	Gender	Date of birth	Height (in cm)	Weight (in Kg)	Mobile Number	Relationship to Proposer	If a registered Medical Practitioner, please provide Medical registration number, council

								name and address of workplace*
1		(M / F /Other)	(dd/mm/yyyy)					

Base coverage:	
Policy type#:	Individual
Number of lives to be covered:	1
Base Sum Insured:	_____
Policy term:	1 Year

3. Portability

Policy No	Insurance company	Risk start date	Risk end date	Reasons for Porting

Name of proposed insured for whom portability is requested	First policy start date	No of years of continuous coverage for which portability is requested	Claims in past policies	Current No claim Bonus	Sum insured – Year 1 (Oldest)	Sum insured- Year 2	Sum insured – Year 3	Sum insured – Year 4 (Expiring policy)

4. Nomination

In the event of the death of the Proposer, claim shall be paid to the Nominee. For other insured persons, Proposer is the nominee. Payment to the nominee constitutes discharge of the Company's full liability.

Nominee Name	Date of Birth	Relationship with the Proposer	Address, mobile no. and email id of Nominee	Appointee Name (if nominee is less than 18 years of age)

Bank Details of Nominee:

Name of the Beneficiary: _____
Bank Name: _____ IFSC Code: _____
Account Number: _____
Account Type:_____

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.

Section A	
Please answer the following questions for each applicant. **Please circle Yes (Y) or No (N)**	**1**

i. 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
ii. 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
iii. Does the Applicant have diabetes or pre-diabetes or has he/she EVER had high blood sugar?	Y	N
iv. Does the Applicant have Hypertension or High Blood Pressure?	Y	N
v. Has the Applicant ever been diagnosed or treated for any genetic / hereditary disorders or HIV / AIDS?	Y	N
vi. Has the Applicant ever been diagnosed or treated for any mental/ psychiatric disorders?	Y	N
vii. Has the Applicant ever been diagnosed with any gynecological disease for which any intervention, hormonal replacement therapy or medication exceeding 5 days have been prescribed?	Y	N
viii. If the Applicant has ever been pregnant then have there been any complication in pregnancy?	Y	N
ix. Has the Applicant ever had any abnormal vaginal bleeding or irregularities in menstruation?	Y	N

Section B: For questions marked Yes (Y) in Section Above, please specify following information:										
Applicant Number	**Details of symptom(s) or investigation(s) or diagnosis or procedure / surgery undergone**				**Duration of condition**	**Medication(s)**	**Dosage**	**Current status (e.g. Complete / partial recovery or ongoing treatment)**	**Treating doctor's name & contact details**	**Documents attached (Yes / No)**
	If Diabetes HbA1c Level	**If High blood pressure BP Level Systolic / Diastolic**	**Any Other Details**	**Onset date (DD/ MM/ YYYY)**						

6. **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.

7. Vernacular declaration

__if the Proposer has signed in vernacular: The content of this form have been explained by me, _____*Name of the person certifying* _ in __*Language* __, in presence of _____*Name of witness*___ to the Proposer who has understood and confirmed the same. Witness must be someone other than agent/ employee of the Company.

Dated _ _/_ _/_ _ _ _ Place_____ Signature of the Proposer_____

Signature of the certifying Person_____ Mobile number of the certifying Person _____
Signature of the Witness_____ Mobile number of the Witness _____

8. Declaration if form is NOT filled by the proposer & Advisor declaration

Declaration if for any reason, the proposal and other connected papers are not filled by the Proposer.
The contents of the proposal form have been fully explained to me and I have fully understood all aspects and implications. The Proposal Form is filled by ____*Name*____, ___*Mobile no*___ under my instruction and I found all information to be correct & complete.

Signature of the Proposer _____

Advisor declaration: I 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 product / proposal to the Proposer
Signature of the Insurance Advisor_____ Intermediary code: _____

9. Premium details (for office use only)

Premium payment option ☐ Cheque ☐ Demand Draft ☐ Credit card / Debit card ☐ Net Banking ☐ Cash ☐ Others
Premium amount_____
Premium paid by_____ Relationship with proposer_____
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

10. Details for Refund & Payment of Claims of Proposer

Option to receive payment: Bank Transfer

Name of the Beneficiary: _____
Bank Name: _____ IFSC Code: _____
Account Number: _____
Account Type:_____

11. Renewal

Renewal payment sign-up:
Payment of renewal premium of your health insurance Policy can be made every year through continuing your existing Automated Clearing House (ACH) / Standing Instructions (SI) with the Company. Under this option, your Policy can be renewed promptly, but subject to you completing all additional requirements of information and documentation as may be required by the Company.
___ I want to opt for the ACH/SI renewal option and thereby avail a discount of 2.5% on the premium till the time policy is renewed using the same.
Dated _ _/_ _/_ _ _ _ Place_____ Signature of the Proposer_____

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

Branch Code _____ SP Code _____ RM/LG code _____
Customer account number _____

13. Statutory Warning

Prohibition of Rebates (Under 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 liable for a penalty which may extend to ten lakh rupees.

14. 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

15. Insurance Advisor's Report (for office use only)

1. Are you related to the Proposer? Yes/No; If yes, nature of relationship? _____
2. For how long have you known the Proposer? Years _ _ _ _ Month _ _
3. Are you satisfied with the identity of the Proposer? _____ Yes _____No
4. Does the Proposer or any applicant have any physical deformity/defect or mental retardation? ___ Yes ___No
5. Have you explained the exclusions of the policy and has the Proposer personally completed the health declaration? ___ Yes ___No
6. What is the Proposer's state of health at the time of making of this proposal form? _____
7. Do you recommend acceptance of this proposal form considering all the factors including moral hazard? ___ Yes ___No
8. Have you dispassionately advised the Proposer and provided all material information to enable the Proposer to decide in the best cover that would be in his / her interest? ___ Yes ___No

Date_____ Signature of Insurance Advisor_____

16. ABHA ID

Member Name	Do you have ABHA ID?	ABHA ID	Consent to share Medical Records with Insurers/TPA's through ABHA
	Yes/No	XX-XXXX-XXXX-XXXX	Yes/No