niva Bupa Health Insurance

Saral Suraksha Bima, Niva Bupa Health Insurance Co. Ltd. - Proposal Form

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:

Name [ ][F][I][R][S][T][ ][N][A][M][E][ ][M][I][D][D][L][E][ ][N][A][M][E][ ][L][A][S][T][ ][N][A][M][E][ ][ ]

Gender [ ] Male [ ] Female [ ] Third Gender Date of Birth [D][D][M][M][Y][Y][Y][Y]

Address

Land Mark City

District State

Pin-code Email Id

Mobile. Account number

PAN No. Nationality

Occupation: [ ] Salaried [ ] Self-employed [ ] Student [ ] Housewife [ ] Other, please specify ____________________

Annual income (Rs)____________________ CKYC number (optional): ____________________

Do you want the Physical Copy of the Policy Kit [ ] Yes [ ] No

[ ] 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 someonewho 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)

2- DETAILS OF APPLICANTS & PLAN SELECTION:

Applicant Number	Name	Gender (Male/ Female/Other)	Height (Feet & Inc.)	Weight (Kg)	Date of Birth (dd/mm/yyyy)	Mobile Number	Relationship to Proposer	Sum insured Individual
1.								
2.								
3.								
4.								
5.								
6.								

3- COVERAGE SELECTION:

Base coverage:	
Policy type:	☐ Individual
Number of lives to be covered:	Adults_____________ Children ______________
Death (Base Sum Insured)	
Permanent Total Disability (PTD)	Up to Base Sum Insured
Permanent Partial Disability (PPD)	Up to Base Sum Insured
Policy term:	☐ 1 Year

Optional coverage:	
Temporary Total Disability (TTD)	☐ YES ☐ NO
Hospitalisation Expenses due to Accident	☐ YES ☐ NO
Education Grant	☐ YES ☐ NO

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 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:

In respect of any of the persons proposed to be insured:	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Are you in good health and/or not suffering from any mental/physical impairment and/or deformity and/or disablement since or after birth?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

6- DECLARATION:

☐ 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.

☐ 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 ______________________________

7- 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 ____ under my instruction and I found all information to be correct& complete.

Signature of the Proposer ______________________________

Advisor declaration: Ias 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: ___________________________________

8- 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

9- NEFT & BANK DETAILS:

All payments (refund of premium, claims etc) would be made electronically ONLY to your account. Please provide following details

Bank Name ________________________________ Branch ______________________________ City_______________________________

Account number ____________________________ IFSC Code _________________________ Account type: ☐ Savings ☐ Current

10- 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____________________________

11- ADDITIONAL DETAILS FOR BANCASSURANCE CHANNEL ONLY (FOR OFFICE USE ONLY):

Branch Code ________________________________ SP Code _________________________ RM/LG code _______________________

Customer account number __________________________________

12- 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.

13- ABHA ID

Member Name	Do you have ABHA ID?	ABHA ID	Consent to share Medical records with insurers/TPA's through ABHA
	☐ Yes ☐ No	☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐	☐ Yes ☐ No
	☐ Yes ☐ No	☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐	☐ Yes ☐ No
	☐ Yes ☐ No	☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐	☐ Yes ☐ No
	☐ Yes ☐ No	☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐	☐ Yes ☐ No
	☐ Yes ☐ No	☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐	☐ Yes ☐ No
	☐ Yes ☐ No	☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐	☐ Yes ☐ No

14- Details for Refund and Payment of Claims

Option to receive payment: ☐ Bank Transfer

Name Of the Beneficiary:____

Bank Name: ____________________ IFSC: ____________________

Account Number: ____

Account Type: ____

15- 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____

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