THE NEW INDIA ASSURANCE COMPANY LIMITED

Registered & Head Office- 87, M.G. Road, Fort, Mumbai-400001.

PROPOSAL FORM FOR GROUP MEDICLAIM INSURANCE POLICY

(to be completed by the Group / Association / Institution / Corporate Body)

IMPORTANT

a. **The Company will not be on risk until the Proposal has been accepted by Company and the full premium paid.**

b. **Employee's / Member's Personal Statement Form should be completed by each employee / member for himself / herself and his / her eligible family members as per Annexure II.**

PROPOSER DETAILS

1. **Name of the Proposer**
(Capital Letters)

2. **Description of the Proposer's Business**

3. **Address for communication**

Tel. / Fax Nos. & email address

4. **No. of persons to be covered**
(List of persons for each Sum Insured Opted as per table)

Sum Insured
In Words :

5. **Please state whether all eligible members of the Group / Association / Institution / Corporate Body are proposed for Insurance** **YES / NO**

6. **Do you require Maternity Expenses Benefit Extension (Strike out whichever is not applicable)** **YES / NO**

7. **Period of Insurance : From** **To (Midnight)**

Place :

Date : **Signature of the Proposer**

Section – 41 Of Insurance Act, 1938 Prohibition of Rebates

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 prospectus 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 five hundred rupees.**

NB : Insurance is the subject matter of solicitation.

THE NEW INDIA ASSURANCE COMPANY LIMITED

Regd. & Head Office : 87, Mahatma Gandhi Marg, Fort, Mumbai – 400 001.

Revised Group Mediclaim Insurance Policy

LIST OF PERSONS PROPOSED FOR INSURANCE

Note : 1. This list will be attached to and forming part of the proposal form and policy to be issued. 2. Separate list should be attached in respect of persons proposed to be covered under each Sum Insured.

Name of the proposer

Sum Insured to be covered in respect of the persons listed below :

SR. NO.	Name of the Employee / Member with Salary Roll No.	Names of Employee's / Member's family members to be covered	Relationship of the dependant members to the Employee / Member	Age / Sex	Sum Insured	Pre-existing disease / injury to be excluded under the Policy
1						
1.1						
1.2						
1.3						
2						
2.1						
2.2						
2.3						
3						
3.1						
3.2						
3.3						
4						
4.1						
4.2						
4.3						
5						
5.1						
5.2						
5.3						
6						
6.1						
6.2						
6.3						

Note : 1. Additional sheet to be attached, if space not sufficient to complete details.

2. Names of the family members to be covered should be mentioned immediately after the name of each employee / Member.

Place :

Date : **Signature of the Proposer**

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REVISED GROUP MEDICLAIM INSURANCE POLICY PROPOSAL
EMPLOYEE'S MEMBER'S PERSONAL STATEMENT FORM

(To be completed by each Employee / Member in respect of himself / herself and his / her eligible family members proposed to be covered)

1. Details of Employees / Members including family members proposed for Insurance

SR. NO.	Name of Employee / Member and eligible family members	Date of Birth /Age	Sex	Occupation	Relationship with the Employee / Member	Monthly Income	*** (pre-existing disclosure)
a							
b							
c							
d							
e							
f							
g							

***** Details of any knowledge of any positive existence of or presence of any ailments, sickness or injury which may require medical attention in immediate future and / or details of any ailment, sickness or injury which had been treated in the past.**

2. Are anyone suffering / suffered from Diabetes / Hypertension / Chest Pain or Coronary Insufficiency or Myocardial Infarction. If so, give full details with Adverse Medical History form.

3. Residential address of the Employee / Member :

4. Name and address of family doctor, including telephone number, if any :

Telephone No. **Doctors Registration Number**

I declare that all the statements made above and the answers given on my behalf and on behalf of the family / members are wholly true and correct to the best of my knowledge and belief. I have disclosed all particulars materials to the risk. It is hereby understood and agreed that the statements, answers and particulars are the basis on which this Insurance is being granted. If, after the Insurance is effected, it is found that the statements, answers or particulars are incorrect or untrue in any respect, the Company shall have no liability under this Insurance in respect of myself and my family members proposed for Insurance.

Place :
Date :

Signature of the Employee / Member
For himself / herself and/or on behalf
Of other family members to be covered.

EMPLOYEE/ MEMBER NAME
LIST SR. NO. / EMP. NO. / ID NO
SUM INSURED Rs
PREMIUM Rs.