

Proposal Form for Reliance Critical Illness Policy

The Policy does not commence until the proposal is accepted by the Company and the full premium is paid.

Intermediary Details (To be filled in BLOCK LETTERS)

Intermediary Name Code
Branch Name Code

Proposer's Details (To be filled in BLOCK LETTERS)

1. Proposer's Full Name Mr. Ms.
2. Address of the proposer

Phone Mobile
Email Fax

Insured Details

Sr. No.	Name of the person to be Insured	Gender	DOB	Relationship with Proposer	Occupation	Sum Insured	Nominee Name and Relationship	Fitness Declaration
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

Policy Details

3. Policy Tenure 1 Year 3 Years Sum Insured 5L 7L 10L 15L 20L
4. Policy Start Date Policy End Date

Family Doctor Details

5. Doctor's Full Name Dr.
6. Address of the Doctor

Phone Mobile
Email Fax

Medical History Declaration

8. Has any of the persons proposed for Insurance (name to be specified in the relevant column) suffered/diagnosed from any of the listed illness?

	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of proposed insured		<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of proposed insured
a. Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	b. Major Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
c. Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	d. Third Degree Burns	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
e. Aorta Graft Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	f. Heart Valve Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
g. Coma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	h. Quadriplegia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
i. Total Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	j. End Stage Renal Diseases (not involving transplant)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>

9. Has any of the persons proposed for insurance, suffered from or currently suffering from?

Name of Proposed Insured

- a. Diseases of Circulatory System (e.g. heart trouble, chest pain, rheumatic fever, heart valve diseases, pacemaker, arrhythmias, congenital heart diseases, high blood pressure, diseases of the arteries and veins)? Yes No _____
- b. Diseases of the Respiratory System (e.g. tuberculosis, asthma, persistent cough, pneumonia or emphysema)? Yes No _____
- c. Diseases of Genitourinary System (e.g. kidney /genito-urinary tract infection/diseases, prostate/cervical diseases, venereal diseases)? Yes No _____
- d. Diseases of Gastrointestinal System (e.g. digestive disorder, gastric or duodenal ulcer, hepatitis B/hepatitis C, or other disorder of Liver/Gall Bladder/Intestine/Pancreas)? Yes No _____
- e. Diseases of the nervous system or mental disorder (e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches, memory loss, nervous breakdown, depression or psychiatric disorder)? Yes No _____
- f. Diabetes Mellitus/Insidipus, Cancer, or Tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes or skin? Yes No _____
- g. Unexplained night sweat and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands? Yes No _____
- h. Any history of major accident or spinal diseases/injury/bony/joints deformity? Yes No _____
- i. Name of any other diseases/illness not mentioned above? _____
- j. In past 2 years have you ever consulted a Doctor or under gone any test like Ultra Sonograms, CT Scan, 2D Echocardiography, ECG, or Biopsy? Yes No _____
- k. Have you ever been advised by the Doctor for Hospital admission/treatment or Surgery or to be on regular medication? Yes No _____
- l. Have you ever been treated or consulted a Doctor for bad effects of excess alcohol consumption or drug addiction or smoking or tobacco usage? Yes No _____
- m. Have you or any of your immediate family members (Father, Mother, Brother, Sister) have/had complaints of Cancer/Heart Attack or Stroke? Yes No _____
- n. Have you received or currently receiving any Personal Accident, Disability Benefit, Critical Illness/ medical-related payments? Yes No _____

10. If your answer to any of the above is YES, please provide complete details of the illness/disease/condition in the table below (Attach extra sheet if required):

Sr. No.	Name of the family member	Details of disease/illness/injury suffering from	Treatment/Medication received/receiving	Month and year when first treated	Name of attending Medical Practitioner/Surgeon with address and telephone no.

Details of other Insurance Policies

Details of any other insurance like Mediclaim/Critical Illness/Personal Accident or any other Medical Insurance Policy currently held by you or any other person to be covered under this Policy.

Policy No.	Name of Insured/ Spouse	Sum Insured	Period of Insurance		No Claim Bonus/ Cumulative Bonus Accumulated	Claim Received/ Receivable	Name and Address of Insurance Company
			From	To			

Payment Details

Mode of Payment Cheque DD Cheque or DD Amount _____ /-

Bank and Branch Name _____

Cheque/DD No. _____ Cheque/DD Date | d | d | m | m | y | y | y | y |

Account Holders Name _____ Relationship with Insured _____

Declaration

I/We hereby declare that the statements, answers and particulars given by me / us in this proposal form are true to the best of my/our knowledge and belief. It is hereby understood and agreed that the statements, answers and particulars provided hereinabove are the basis on which this insurance is being granted and that if, after the insurance is effected, it is found that any of the statements, answers or particulars are incorrect or untrue in any respect, the Company shall have no liability under this insurance.

I/We agree and undertake to convey to Reliance General Insurance Company Limited any additions/alterations carried out in the risk proposed for insurance after submission of this proposal form.

Place: _____
Date: _____

Signature of Proposer

Section 41 of The Insurance Act, 1938

- 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 or 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.
- Any person making default in complying with the provisions of this Section shall be punishable with fine which may extend to Rs. 500/-