THE ORIENTAL INSURANCE COMPANY LIMITED

HEAD OFFICE : A-25/27, ASAF ALI ROAD, NEW DELHI - 110002

HAPPY FAMILY FLOATER POLICY

PROPOSAL FORM

i PROPOSAL FORM AND SELF DECLARATION FORM TO BE FILLED IN BLOCK LETTERS AND IN DUPLICATE.

ii PLEASE ATTACH TWO STAMP SIZE PHOTOGRAPHS OF EACH INSURED PERSON.

iii THE COMPANY WILL NOT BE ON RISK UNTIL THE PROPOSAL HAS BEEN ACCEPTED BY THE COMPANY AND COMMUNICATION OF THE ACCEPTANCE HAS BEEN MADE TO THE PROPOSER IN WRITING ON RECEIVING FULL PAYMENT OF PREMIUM.

iv ANY PERSON BEYOND 60 YEARS OF AGE DESIRING TO TAKE INSURANCE COVER HAS TO UNDERGO PREINSURANCE HEALTH CHECK UP THROUGH COMPANY'S LISTED DIAGNOSTIC CENTRE AND 50% OF THE COST OF SUCH EXPENSES TO BE REIMBURSED BY THE COMPANY AFTER ACCEPTANCE.

1. NAME OF THE INSURED PERSON AND RELATIONSHIP WITH THE PROPOSER.

S No.	Name of the insured	Relationship with Proposer	Sex M/F	Whether dependant on the proposer Y / N	Date of Birth	Age (in completed years)	Occupation	Sum Insured for family (Rs.)
1.								
2.								
3.								
4.								
5.								
6.								
7.								

S.No.	Plan opted							Sum Insured opted for P. A.
	Silver		Gold					
	Without Add-on	with P.A.	without Add-on	with P. A.	With Plan 'B'	With Plan 'A' + P.A.	With Plan 'B' + P.A.	
1.								
2.								
3.								
4.								
5.								
6.								
7.								

2. PLAN OPTED :

3. ADDRESS & TELEPHONE NO. / MOBILE NO. / E-MAIL ADDRESS :

												Mobile No.												
Ph. No												Email												

4. PERMANANT ACCOUNT NO. (ISSUED BY INCOME-TAX AUTHORITIES) :

5. NAME - ADDRESS & TELEPHONE NO OF FAMILY PHYSICIAN

Ph. No												Mobile No.												

6. PLEASE FURNISH DETAILS OF ANY HOSPITALIZATION / ILLNESS / DISEASE AT PRESENT OR IN THE PAST.

S. No.	Name of the insured	Name of the Insurer	Type of Policy (Please specify) P.A., Cancer, Mediclaim, others)	Policy Number	Policy Period
1.					
2.					
3.					
4.					
5.					
6.					
7.					

7. PLEASE GIVE THE DETAILS OF ANY HOSPITALISATION / ILLNESS / DISEASE IN THE PAST 4 YEARS.

S. No.	First Name of the insured	Name of the Insurer	Policy no.	Sum Insured	Period	Remarks
1.						
2.						
3.						
4.						
5.						

8. HAS THE PROPOSER OR ANY OF THE MEMBERS OF THE FAMILY PROPOSED BEEN REFUSED COVER FOR SIMILAR PROPOSAL. IF SO DETAILS THEREOF:

S. No	First Name of the insured	Refusal by insurer	Cancellation of policy by insurer
1.			
2.			
3.			
4.			
5.			
6.			
7.			

9. Do you wish to opt out TPA Service ?

Yes	No

10. PROPOSED DATE & PERIOD OF INSURANCE (DD MM YYYY)

FROM									TO							

DECLARATIONS :

1. 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 bahalf of these other persons.

2. 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 insurance company and that the policy will come into force only after full receipt of the premium chargeble.

3. I further declare that I will notify in writting 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.

4. I declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/ proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured / proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwritting the proposal and / or claim settlement.

5. I authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwritting and / or claims settlement and with any Governmental and / or Regulatory authority.

Place		Signature of Proposer
Date		Name of Proposer

NOTE

In case of death claims, the name of the beneficiary making claim, relationship with the insured and legal status is to be mentioned.

The claim for any of the insured person will be payable in the name of Proposer and discharge voucher signed by him will be considered valid. However, in the event of unfortunate demise of the Proposer during the course of policy period, the claim may be payable to the nominee declared by the Proposer in this form.

Nomination

I .....do hereby assign the amount payable by the Oriental Insurance Company Ltd. under this policy in the event of my death to.....(Relationship to the Insured) and I further declare that his receipt shall be sufficient discharge to the Company.

Dated this.....Day of.....20.....at.....

Signature of Proposer

Signature of Witness
Name and address

PROHIBITION OF REBATES (Section 41 of the Insurance Act 1938 provides)

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 prospectus or tables of the Insurer. Any person making default in complying with provision of this section shall be punishable with fine, which may extend to Rs.500/-.

SELF DECLARATION FORM

(FORM TO BE DULY FILLED BY EACH APPLICANT ONLY IN DUPLICATE)

PERSONAL DETAILS :

1. Name of the Insured : _____

2. Age (in completed years) : _____ 3. Date of birth : _____ Sex : _____

4. Address : _____

_____

5. Telephone No. : _____ E-mail ID : _____

Indentification Document Details : (Photo ID Proof / Ration Card)

PERSONAL HISTORY : (For all insured persons listed in the proposal)

PARTICULARS	YES / NO	DETAILS
A. Are you in good health and free from physical and mental disease of infirmity or majore complaints ?		
B. Have you ever sufferd from any of the following disease / illnesses. Please write Yes / No.		
1. Any Neurological / mental or related diseases ?		
2. Slipped disc or other spinal disorder or paralysis of any kind or fainting episode, blackout, fit.		
3. High blood pressure, palpitation, Heart diseases including ischaemic heart disease, other circulatory disorders including rheumatics fever etc.		
4. Disease of uterus, ovaries, breast or any other gynaecological disorder.		
5. Fistula, Piles, Hernia, Varicose veins etc.		
6. Any disease of bones, Joints, Arthritis including rheumatic disease etc.		
7. Any respiratory disease.		
8. Any allergic diseases.		
9. Any dimness of vision or cataracts etc.		
10. Any disease of ears or difficulty or interference with hearing etc.		
11. Any disorder of the stomach, ulcer, bowel, or gall bladder, kidney etc.		
12. Cancer, malignant growth, boil, cyst or wound etc.		
13. Diabetes or any urinery diseases.		
14. Gential Disorder		
15. Any cerebral or vascular strokes or sudden loss of consciousness or similar disease.		
16. Tuberculosis (TB)		
17. AIDS / HIV / related disorder etc.		
18. Congenital diseases (Since Birth)		
19. (a) Have you ever suffered from dental problem ? YES / NO (b) if yes, specify same (c) When were you treated last for same.		
20. Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigation.		
21. Any other complaint or tendency that may necessitate such consultation or treatment in the future		

(B) **Have you Noticed sudden decrease or increase in your weight in past six month** **Yes / No.**

(C) **Have you visited a doctor / hospital / healthcare unit for evaluation or treatment in recent past if yes, gives details :**

_____

_____

Give Details of hospitalization (Attach Copy of discharge card and doctor's consultation notes and investigation copy)

_____

_____

Past Surgical details : Name of surgery or part operated _____

Date of operation _____ Completely cured YES / NO, give details _____

_____

(Attach Copy of discharge card and doctor's consultation notes and investigation copy)

I the undersigned hereby declare that all the information given by me in this form is true and I understand that any of these details if found untrue on correlation with my medical test or medical examination before or after issuance of policy will affect the coverage and payment of my health insurance benefit under this Mediclaim policy.

Name of applicant _____ Signature :

Date: Place :

MISC : 405 Vee-Kay P. 50,000 sets 1000 Pkts. 50 sets each 70 gsm Ballarpur S.S. maplitho / Nov 2013