



IMD CODE																				
IMD NAME																				
MOBILE No.																				



Bajaj Allianz General Insurance Company Limited

STAR PACKAGE POLICY - PROPOSAL FORM

Important: This proposal for insurance will be the basis of any subsequent insurance policy that we issue to you. It is essential that you answer fully and accurately all of the questions contained in this proposal, and that you provide us with any and all additional information relevant to the risk to be insured or our decision as to the acceptance of the risk or the terms upon which it should be accepted. Your failure to comply with this obligation now may result in the rejection of your claim and the avoidance of your policy when a claim is made. If you are in any doubt about the information to be given, please seek the advice and guidance of your insurance advisor or agent. If there is insufficient space in this proposal for you to provide relevant information, whether as requested or otherwise, please attach a separate sheet to this proposal and return it to us.

PLEASE ANSWER EVERY QUESTION AND FULLY

Proposer Details :

1. Name of the Proposer

2. Address Res :

City State

PIN Mobile

3. E-mail ID _____

4. Name and address of the Family Doctor _____

5. Monthly income _____

6. Coverage - Minimum three sections to be opted. Please encircle the cover to be opted

Section	Products	Plan A	Plan B	Plan C	Plan D
1	Hospital Cash	500	1000	2000	2500
2	Health Guard	100000	200000	300000	500000
3	Critical Illness	100000	150000	200000	300000
4	Personal Accident	200000	300000	400000	500000
5	Education Grant	200000	300000	400000	500000
6	Householders contents	100000	200000	300000	400000
7	Traveling Baggage	10000	20000	30000	40000
8	Public liability	200000	300000	400000	500000

Add on cover for Health Guard : 1 2 3 4

7. Critical Illness : Please Indicate if you are opting for Family Floater: Yes / No

(i) Spouse (ii) Spouse + 1 Child (iii) Spouse + _____ Children



8. Total No of sections opted for _____

9. Details of the persons to be insured

Details of person(s) proposed to be insured

Sr. No.	Name of Insured Person	Date of Birth	Ht.	Wt.	Relationship	Name Illness / Disease / Disability suffered or suffering from	Duration of Illness	Assignee

1. Education Grant payable only in case of Accidental Death & PTD.
2. Education Grant & Personal Accident cover available only for proposer.
3. Household contents (First Loss) Fire perils including earthquake and burglary.
Any valuable with value more than 5 % of SI under this section to be specifically declared along with value otherwise will be excluded.
4. Traveling Baggage - Anywhere in world, valuables excluded.

Declaration: I hereby declare and warrant that the above statements are true and complete in all respects and that there is no other information which is relevant to my application for insurance for my insurance, that has not been disclosed to you. I agree that this proposal and the declarations shall be the basis of the contract between me and Bajaj Allianz and I agree to accept a policy, subject to conditions prescribed by Bajaj Allianz.

APPLICANT'S SIGNATURE

DATE (DD/MM/YY)

Period of Insurance starting from

TO

INSURANCE ACT 1938 SECTION 41- Prohibition of Rebates. 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 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 FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO FIVE HUNDRED RUPEES.

Annexure – Critical Illness Questionnaire

(To be filled only if Section III – Critical Illness Opted For)
Individual forms to be filled for every person covered

APPLICANT DETAILS AND PROOF OF AGE

Name : Mr./ Mrs. (Surname) (First Name)

Gender: Male [] Female [] Birth Date: [][][][][][][][][]

Marital Status : Married [] / Single [] Divorced [] / Widowed []

Please provide a copy of any of the following documents as proof of age:

- PASSPORT []
MUNICIPAL BIRTH CERTIFICATE []
SCHOOL OR COLLEGE CERTIFICATE []
IDENTITY CARD []
PAN CARD []
OTHERS PLS SPECIFY []

OTHER INSURANCE DETAILS :

Do you have other current or pending critical illness/health insurance/Hospital Cash Policy with BAGICL? Yes [] / No []

If yes, policy number:.....

Do you have other current or pending any of the above insurance policy with another company? Yes [] / No []

If yes: Name of Company..... Sum Insured.....

Period of Cover.....

Has any proposal for life, medical, health, accident, disability cover, critical illness or any other health-related insurance on your life ever been postponed, declined or accepted on special terms? Yes [] / No []

If Yes, Give Details including amount applied for.....

HEALTH STATUS :

PLEASE ANSWER ALL QUESTIONS BY CHECKING EITHER THE YES OR NO BOX

Are you now in good health and entirely free from any mental or physical impairments or deformities? Yes [] / No []

Height..... (Cms) Weight.....(Kg.)

How much weight have you lost or gained over the last 12 months? (Kg.).

Reason for weight

Change.....

Have you ever suffered or do you now suffer from:

- Diseases of the circulatory system (e.g. heart trouble, chest pain, rheumatic fever high blood pressure, diseases of the arteries and veins or any other)? Yes [] / No []
• Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia of emphysema of any other)? Yes [] / No []
• Diseases of the genitor-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)? Yes [] / No []
• Diseases of the gastrointestinal system (e.g. digestive disorders, gastric or

duodenal ulcer, hepatitis B or other disorder of the liver, disorders of the gall bladder)?

• Diseases of the nervous system or mental disorders (e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown, depression or other mental or psychiatric disorder)? Yes / No

• Diabetes mellitus, cancer or tumour of any kind, or any diseases of blood, glands, spleen, ears, eyes or skin? Yes / No

• Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhoea, unexplained infection or swollen glands? Yes / No

• Any Congenital/birth defects/diseases? Yes / No

• Any other diseases or ailments not mentioned above? Yes / No

Give details.....

• Have you or any of your immediate family members (father, mother, brother, or sister) have/had cancer, heart attack, or stroke and at what age? Prior to age 60? Yes / No

• Have you ever had or been advised to have hospital treatment or surgery? Yes / No

• Have you ever had or been advised to have a blood test for AIDS or An AIDS related condition or have you ever been refused as a blood donor? If Yes: Result of the Blood Test Yes / No

Test:.....

• In the past 5 years, have you consulted a physician for any reason or have you had any investigation such as blood or urine tests, X-rays, electrocardiograms, ultra sonogram, CT scans or biopsy, other than for routine employment or immigration purposes? Yes / No

• Have you ever received or do you now receive any disability benefit, disability pension, or disability related payments? Yes / No

• Are you at present on any medication, special diet, or treatment? Yes / No

• Have you ever taken narcotics or other habit forming drugs or been treated or advice in connection with your alcohol consumption or the taking of drugs? Yes / No

• Do you participate or do you intend to participate in any hazardous sports or activities such as motor sports, climbing, parachuting, hang-gliding, or aviation except as a fare-paying passenger? Yes / No

• Are you pregnant (for female only)? If yes, please state how many months. Yes / No

• Have you smoked or used any substance or product containing tobacco, nicotine or marijuana in any for in the last 12 months? Yes / No

If yes, please state duration and average daily consumption and type :

.....

Name and address of your regular medical consultant/Family Physician:

.....

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If you answered "yes" to any of the questions numbered 1 to 13 (in Section 3 Health Status), please give complete details (including dates, duration and treatment, names and addresses of physicians)

Date _____

Signature _____