The New India Assurance Company Limited

Head Office: 87, M G Road, Fort, Mumbai-400001

MEDICLAIM INSURANCE PROPOSAL FORM

Photograph

AGENCY CODE: ______________ DEV. OFFICER CODE: ___________________

POLICY NO.: __________________ ANNUAL PREMIUM RS.___________________

IMPORTANT

a) The Company will not be on risk until the Proposal and Insured persons details have been accepted by the Company and communication of the acceptance has been given to the proposer in writing on full payment of premium.
b) If other family members residing with proposer i.e. spouse, eligible dependent children and dependent parents required to be covered, separate Insured Person details forms should be completed for each of such family members.

PROPOSER DETAILS

1. Name of Proposer: _______________________ _______________________
   (Surname) (Name)

2. Address and Telephone No: i. Residence:

   ii. Office:

3. Total number of members to be covered (in figures):
   (in words):
   (Separate Insured Person Details forms to be enclosed)

4. Period of Insurance: From __________________ to _________________(midnight)

Place:
Date: Signature of the proposer

SPECIMEN SIGNATURE TABLE

S.N.	Name of Insured Person	Age	Sex	Relation	CSI	Signature
1						

2						
3						
4						
5						

Photographs of Insured persons:

Photograph	Photograph	Photograph	Photograph	Photograph

PROHIBITION OF REBATE

Section 41 of the Insurance Act 1938

i) 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 insurers.

ii) Any person making default in complying with the provisions of the section ***shall*** *be punishable with fine which may extend to five hundred rupees.*

INSURED PERSON DETAILS

Policy No. :
Insured Person No.:
Annual Premium:
To be completed separately including Questionnaire form for each insured person. (If more than one insured Person is required to be covered please obtain additional forms from the company).

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1. Name of the Insured Person: ____________________ FOR OFFICE USE 2.
Address: ____________________________________

____

State/U. Territory:
3. Sex (Strike out Which ever is not applicable): Male/Female
4. Relationship with the proposer :
5. Date of Birth and age :
6. a) Average monthly income Rs. :
b) Income Tax PAN No. :
7. Profession/Occupation/Trade or Business :
(Please describe fully with nature of duties)
Pin Code :
Tel No. :
State/U. Territory :
8. Name and address of the Medial Practitioner,

his qualification & Telephone No. If any. :
Pin Code :
Tel No.
State./U. Territory

9. Medical Practitioner's Regn. No. :

10. Are you at present or any other time in the past covered under any other Insurance Type (PA, Cancer Insurance. Hospitalistion Insurance or other Medical Insurance) :
If So, give particulars of -

a) Insurer, policy No. and period of cover :
b) Claim Amt. Recd./receivable :
Period................From .... To ....

11. Any proposal for this Insurance or any other similar insurance refused or cancelled or higher premium charged, if so give details. :

12. Medical history to be completed by the proposer/insured person :
Please answer the following questions in yes or no (A dash is not sufficient) and give full details if answer is yes.

12.1.Are you in good heath and free from physical and mental disease of infirmity or medical complaints ? :

12.2. If not in good health give full details. :

13. Have you ever suffered any of the diseases/illness? If yes, give details

a) any nervous, mental or psychiatric disease :
b) Slipped disc or other spinal disorder or (fainting episode, blackout, fit) paralysis of any kind. :
c) High blood pressure, heart diseases, including ischaemic heart disease, other circulatory disorder etc. (rheumatic fever) :
d) Fistula, piles, hernia, varicose veins :
e) Any disease of the bones or joints including rheumatic disease :
f) Disease of uterus, ovaries or breast or any specific gynaecological disorders. :
g) Any respiratory or allergic disease :
h) Any disorder or the stomach, ulcer, bowel or gall bladder, kidney stones etc. :
i) Any cancer, malignant growth, boil, cyst or wound etc. Which does not heal or improve despite treatment. :
j) Any other complain requiring specialist's consultation or surgical or hospital treatment or investigations. :
k) Any complain or tendency that may necessitate such consultation or treatment in the future :
l) Any dimness of vision/cataract :
m) Any disease of ears or difficulty or interference with hearing :
n) Diabetes or any urinary diseases :
o) Any other illness or disease or accident of operation sustained by you :

14. Have you ever suffered from dental problems? Yes/No.
p) If yes, specify same :
q) When were you treated last for same :

15. Give particulars in table below of any other illness or disease or accident or operation sustained by you in the past.

S.No.	Nature of illness/disease injury and treatment received	Date first treated	Name of attending medical practitioner, surgeon with his address and Telephone No.	Whether fully cured
1				
2				
3				
4				

16. Are there any additional facts affecting the proposed insurance which should be disclosed to Insurers? :

17. Please give details of any knowledge of any positive existence or presence of any ailment, sickness or injury which may require medical attention.
1.
2.
3.
4.

18. Please specify Sum Insured opted : Rs.

I hereby declare and warrant that the above statements are true and complete. I consent authorise the Insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended or may attend concerning any disease or illness which affects my physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be effected. If after the insurance is effected, it is found that the statements, answers or particulars stated in the Proposal form and its Questionnaires are incorrect or untrue in any respect, the Insurance Company shall incur no liability under this insurance.

I have read the Prospectus and I am willing to accept the coverage subject to the terms, conditions and exceptions prescribed by the Insurance Company herein.

Date:.......................

Place:.....................

Signature:.......................................

DD☐☐ MM ☐☐ YY ☐☐

Name of the proposer/ insured person (IN BLOCK LETTERS)
....

N:B This should necessarily be signed by insured. In case of minor, guardian or proposer may sign.

FOR OFFICE USE

Basic Premium for Scheme Rs. ....
Family Discount Rs. ....
Staff Discount Rs. ....

TO BE COMPLETED BY PROPOSER IN CASE OF ADVERSE HISTORY IN THE PROPOSAL FORM IN RESPECT OF APPLICABLE ILLNESS

Annexure-A

DIABETES QUESTIONNAIRE

1. Date of diagnosis of Diabetes:
2. Did you suffer from coma or procoma?
3. Do you take any antidiabetic drugs? If so, please give names with dose:
4. Please give details of fasting and postprandial Blood sugar Readings: ECG findings and other investigation reports with dates. Please also send reports:
5. Do you suffer or have suffered from any complication of Diabetes or any other diseases?

HYPERTENSION QUESTIONNAIRE

1. What is your Bloodpressure reading, please state with dates?
2. Please state names of antihypertensive drugs with dose:
3. Are you a srnoker?
4. Is It Essential/Secondary/Malignant Hypertension?
5. Please state whether you have suffered from any complications or other diseases:
6. Please give findings of all investigation reports:

CHEST PAIN OR CORONARY INSUFFICIENCY OR MYOCARDIAL INFARCTION QUESTIONNAIRE

1. Did you ever suffer from chest pain or coronary insufficiency or myocardial Infarction ? If so, please give diagnosis and date:
2. Please state the names and dose of drugs you are taking at present:
3. Please state the findings with dates of Investigations done like ECG, Stress test, coronary angiography, X-ray pathology reports etc. Please send reports with the proposal arm:
4. Please state the date of hospitalisalon and names of hospitals and consultants:
5. Please state complications and other diseases suffered:
6. Please state whether you can do your regular work and whether you have any limitation of activity:
7. Are you advised any special treatment 7 If so, please give Information:

Place:

Date: *Signature of Proposer*

TO BE COMPLETED BY CONSULTING PHYSICIAN / SURGEON (IN CASE OF ADVERSE MEDICAL HISTORY)

Annexure- "B"

1. Name of the Insured:
2. History
   a) Present complaints and Investigation, if any:

b) Any past history of diseases, operations, accidents, Investigations with date, major medical complaints or hospitalisation:

c) Details of present and past medication with duration:

d) Is he cured of diseases, if any, given, stopped?

3. General Examination:
4. Systematic Examination:

Signature of Proposer:

Date:
Place:

Signature of Consulting Physician:

Name of Consulting Physician:
Qualification:
Address:
Telephone Number:

TO BE COMPLETED BY OFFICIAL OF INSURANCE COMPANY

DOYOU CONSIDER THE RISK ACCEPTABLE?

Competent Authority:
Branch Manager:
Divisional Manager: