## THE ORIENTAL INSURANCE COMPANY LIMITED,
## HEAD OFFICE: A-25/27, ASAF ALI ROAD, NEW DELHI 110002

# HAPPY FAMILY FLOATER POLICY

## PROPOSAL FORM

1. **PROPOSAL FORM AND SELF DECLARATION FORM TO BE FILLED IN BLOCK LETTERS AND IN DUPLICATE.**
2. **PLEASE ATTACH TWO STAMP SIZE PHOTOGRAPHS OF EACH INSURED PERSON.**
3. **THE COMPANY WILL NOT BE ON RISK UNTIL THE PROPOSAL HAS BEEN ACCEPTED BY THE COMPANY AND COMMUNICATION OF THE ACCEPTANCE HAS BEEN GIVEN TO THE PROPOSER IN WRITING ON RECEIVING FULL PAYMENT OF PREMIUM.**
4. **THE INSURED ABOVE 60 YRS. OF AGE HAS TO UNDERGO PRE INSURANCE HEALTH CHECK UP THROUGH COMPANY'S AUTHORISED DIAGNOSTIC CENTRE AND COST OF SUCH EXPENSES TO BE BORNE BY HIM.**

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

| S No | Name of the insured | Relation ship 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. | | | | | | | | |

**2. PLAN OPTED:**

| 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 'A' | With Plan 'B' | With Plan 'A'+P.A. | With Plan 'B'+P.A. | |
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| 4. | | | | | | | | | |
| 5. | | | | | | | | | |
| 6. | | | | | | | | | |
| 7. | | | | | | | | | |

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

| | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | Mobile No | | | | | | | | | | | | |
| Ph.No | | | | | | | | | | E-mail | | | | | | | | | | | | | | |

**4. PERMANENT 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 (Pleas 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** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**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. NAME OF THE NOMINEE IN THE EVENT OF DEATH OF INSURED DURING THE COURSE OF TREATMENT.**

| **S.No.** | **First Name of the insured** | **Name of the Nominee** | **Relationship with Insured** |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |
| **5.** | | | |
| **6.** | | | |
| **7.** | | | |

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

| FROM | | To | |
|---|---|---|---|

I/we declare that the statements made by me/us in this proposal form are true and to the best of my / our knowledge and belief and I/we hereby agree that this declaration shall form the basis of the contract between me/us and The Oriental Insurance Company Ltd..

I / we also declare that if any additions or alterations are carried out after the submission of this proposal form and /or issuance of policy document, the same would be conveyed to The Oriental Insurance Company immediately.

I / we hereby agree to and authorise the disclosure to the insurer or the TPA or any other person nominated by the insurer any and all Medical records and information held by any Institution / Hospital or Person from whom the insured person has obtained any medical or other treatment to the extent reasonably required by either the insurer or the TPA in connection with any claim made under this policy or the insurer's liability there under.

I / we further declare that I / we have read the prospectus and have understood the same. I accept the policy, subject to terms, exceptions and conditions prescribed therein and further disclose that on the event of finding any thing contrary to what has been declared by me, I / we shall be held responsible for all consequences thereof and

insurance company shall incur no liability under this insurance.

I / we further declare that the Insurance Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner intentionally or recklessly or otherwise misrepresented or concealed or non disclosure of material facts or making false statements or submitting false bills whether by the Insured Person or Institution / Organization on his behalf. Such action shall render this policy null and void and all benefits hereunder shall be forfeited. Company may take suitable legal action against the Insured Person / Institution / Organization as per Law.

| | | |
|---|---|---|
| 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 Assignee declared by the Proposer in this form.

ASSIGNMENT

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.....200.....at.....

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: _____

**Identification Document Details**:(Photo ID Proof / Ration Card)_____

## PERSONAL HISTORY: (For all insured persons listedin the proposal)

| PARTICULARS | YES / NO | DETAILS |
|---|---|---|
| A. Are you in good health and free from physical and mental diseases or infirmity or major complaints ? | | |
| B. Have you ever suffered from any of the following diseases / 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 diseases, other circulatory disorders including rheumatic fever etc. | | |
| 4 Diseases 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 diseases etc. | | |
| 7 Any respiratory diseases | | |
| 8 Any allergic diseases | | |
| 9 Any dimness of vision or cataract 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 urinary diseases. | | |
| 14 Genital 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 problems? YES/NO<br>(b) If, yes, specify same.<br>(c) When were you treated last for same. | | |
| 20 Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations. | | |
| 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 months** **Yes / No**

**(C)** **Have you visited a doctor /hospital /healthcare unit for evaluation or treatment in recent**

**past if yes, give details:** _____
_____
_____

**Give Details of hospitalization (Attach Copy of discharge card and doctors consultation notes and investigations 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 investigations 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 payments of my health insurance benefit under this Mediclaim policy.**

Name of applicant _____Signature:

Date: Place: