UNITED INDIA INSURANCE COMPANY LIMITED

Registered & Head Office: **24, WHITES ROAD, CHENNAI-600014.**

DIVISIONAL / BRANCH OFFICE.....

Photograph

SUPER TOP UP MEDICARE PROPOSAL FORM

AGENCY CODE: ANNUAL PREMIUM: POLICY NO.:

DEV. OFFICER CODE:

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 and eligible dependent children are required to be covered, separate Insured Person details forms should be completed for each of such family members.

c) *Persons may be required to undergo pre-acceptance health check-up at a recognised Hospital/Nursing Home/Laboratories/Clinic at the cost of insured in some cases as mentioned in the prospectus.*

d) Fresh proposal form is required along with pre-acceptance medical check-up as mentioned in item (c) above, irrespective of age, when there is break in insurance cover or when there is a request for enhancement in the sum insured.

e) **Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy (material fact is one which will enable the Insurer to decide whether to accept the risk and if yes, at what rate, terms and conditions).**

PROPOSER DETAILS

1. Name of the 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 are to be enclosed)

4. Do you wish to have Policy on : Individual basis or Family Floater basis

5. If on family floater basis, indicate option : A / B / C / D / E / F / G / H

6. If on Individual basis, indicate option for each individual person

Self	-	A / B / C / D / E / F / G / H
Spouse	-	A / B / C / D / E / F / G / H
Child -1	-	A / B / C / D / E / F / G / H
Child - 2	-	A / B / C / D / E / F / G / H
Father	-	A / B / C / D / E / F / G / H
Mother	-	A / B / C / D / E / F / G / H

6. Period of Insurance : From ..... To ..... (midnight)

7. SPECIMEN SIGNATURE TABLE

S.No.	Name of Insured Person	Age	Sex	Relation	Signature
1					
2					
3					
4					
5					

Photographs of Insured persons:

Photograph	Photograph	Photograph	Photograph	Photograph

PLACE:

DATE:

Signature of the proposer

Section 41 OF INSURANCE ACT 1938

➢ PROHIBITION OF REBATES ➢

(1) 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 a part of commission payable or any rebates of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate except as may be allowed in accordance with the published prospectus or tables of the insurer.

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

UNITED INDIA INSURANCE COMPANY LIMITED

Registered & Head Office: **24, WHITES ROAD, CHENNAI-600014.**

INSURED PERSON DETAILS

(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).

1. Name of the Insured Person :

2. Address :

PIN CODE | | | | | | |

State / U.Territory

3. Sex (Strike out whichever 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) :

8. Name and address of the Medical Practitioner, his qualifications & Telephone No. if any. :

Pincode: | | | | | | |

Tel. No. :

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, Hospitalisation Insurance or any other Medical Insurance), If so,

(A) Give particulars of current or expiring policy as well as for the previous four years

Insurer	Policy No.	Expiry date	Sum Insured (RS.)	Pre existing Diseases, if any	TPA

Date of first coverage which has since been renewed continuously without break or within grace period ——

(B) Claim amounts received / receivable in preceding five years including expiring policy

Insurer	Policy No.	Claim Amount	Illness	TPA

11. Has any Proposal for this Insurance or any other similar insurance been 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 WITH YES OR NO. (A DASH IS NOT SUFFICIENT) GIVE FULL DETAILS IF THE ANSWER IS YES.

12.1 Are you in good health and free from physical and mental diseases or infirmity or medical complaints?

12.2 If not in good health give full details

13. Have you ever suffered from any of the following diseases / illnesses? If yes, give full details (Use separate sheet of paper if necessary):

(a) Any nervous, mental or psychiatric disease

(b) Slipped disc or other spinal disorder (fainting episode, blackout, fit) paralysis of any kind

(c) High blood pressure, heart diseases, including Ischaemia 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) Diseases of uterus, ovaries or breast or any specific gynaecological disorders

(g) Any respiratory or allergic disease

(h) Any disorder of 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 complaint requiring specialist's consultation or surgical or hospital treatment or investigations

(k) Any complaint 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 or operation sustained by you.

14. (a) Have you ever suffered from dental problems ? Yes / No

- If yes specify same

(b) When were you treated last for the same

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

S.N.	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.				

16. Are there any additional facts affecting the proposed insurance which should be disclosed to the Insurers ? If so, please give full details

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 and 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 am willing to accept the coverage subject to the terms, conditions and exceptions stated therein and expressed in the Policy.

Signature..... Date ...../...../.....

Place:.....

NAME OF THE PROPOSER / INSURED PERSON.....
(IN BLOCK LETTERS)

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

----------FOR OFFICE USE----------

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

DIABETES QUESTIONNAIRE:

1.	Date of diagnosis of Diabetes	
2.	Did you suffer from coma or procoma ?	
3.	Do you take any anti diabetic drugs ? If so please give names with dosage.	
4.	Please give details of Fasting and post prandial Blood Sugar readings, E.C.G. findings and other investigation reports with dates. Please also attach the relevant reports	
5.	Do you suffer or have you suffered from any complications of diabetes or any other diseases?	

HYPERTENSION QUESTIONNAIRE

1.	What is your Blood Pressure reading, please state along with date on which recorded?	
2.	Please state name of antihypertensive drugs, if any, taken by you, along with details of dosage	
3.	Are you a smoker?	
4.	Do you suffer from essential / secondary / Malignant Hypertension?	
5.	Please state whether you have suffered from any complications or other diseases earlier	
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 give please give diagnosis and date	
2.	Please state name and dosage 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 prescribed form.	
4.	Please state the date of hospitalisation and names of hospitals and consultants who treated you.	
5.	Please state complications and other diseases if 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? If so please give information	

PLACE :

DATE: **Signature of Proposer/Insured person**

TO BE COMPLETED BY CONSULTING PHYSICIAN / SURGEON

(in case of adverse Medical History)

1. Name of the Proposer:
2. HISTORY
   a) Present complaints and investigation if any
   b) Any past history of disease, operation, accidents investigations with date, major medical complaints or hospitalisation
   c) Details of present and past medication with duration
   d) Is the proposer cured of disease, if any? When, was your treatment, if any given, stopped?
3. General Examination
4. Systematic Examination
5. Do you consider the risk acceptable

Signature of proposer

Signature of consulting physician

Name of consulting Physician:

Qualifications:

Address:

Place:

Date:

Telephone Number:

TO BE COMPLETED BY OFFICIAL OF INSURANCE COMPANY

DO YOU CONSIDER THE RISK ACCEPTABLE?

COMPETENT AUTHORITY