Samaveshi Suraksha Health Insurance Policy

Proposal Form

Important Instructions

Please read the instructions below carefully before filling out this form

- This policy is specially designed for Persons with Disability, Mental Illness and Persons with HIV/AIDS.
- This Proposal Form shall be the basis of the policy to be issued. Thus, please provide all the information sought in this Proposal Form & all additional relevant information fully & accurately. Please do not leave any space blank or put dashes.
- 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 after payment of requisite premium.
- Pre-policy health check-up reports not older than 30 days are required to be submitted, wherever required at Company's discretion.
- List of documents required is provided in Annexure D.
- Only one policy can be purchased for this product across all insurers.
- Only Indian Nationals can be covered under this policy

I. Proposer Details

Please submit a copy of Aadhaar/Passport/Election Photo ID Card/Latest Electricity Bill/Bank Pass Book as Proof of Address

Name: .....

Date of Birth: DD/MM/YYYY Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Single ☐ Married

Occupation: ☐ Salaried ☐ Self-Employed ☐ Others, please specify .....

PAN Card No: ..... *(Or form 60/61)* Aadhaar Card/Passport No: ..... E-Insurance Account No. ..... *(if available)*

Present Address: .....

City: ..... State: ..... Pin Code: .....

Permanent Address: .....

City: ..... State: ..... Pin Code: .....

Tel. No.: ..... Email ID: ..... Mobile: .....

II. Nomination

Where Nominee is a minor, give the details of Appointee

Nominee Name: ..... Nominee Relationship with the Proposer: .....

Present Address: .....

Permanent Address: .....

Bank A/c Number and IFSC: ..... Email ID: ..... Mobile: .....

III. Coverage Details

Please tick the option selected

Coverage Type: ☐ Pre-Existing HIV ☐ Pre-Existing Disability ☐ Both Pre-Existing HIV & Pre-Existing Disability

Sum Insured Options: ☐ 4 Lakhs ☐ 5 Lakhs Waiver of Co-Payment: ☐ Yes ☐ No

Coverage required from DD/MM/YYYY to midnight of DD/MM/YYYY TPA preference: .....

IV. Insured Person Details

Paste one stamp size photograph and sign below. In case of minor, guardian or proposer may sign

Name: .....

Address: .....

City: ..... State: ..... Pin Code: .....

Tel. No.: ..... Email - ID: ..... Mobile: .....

PAN Card No: ..... Aadhaar /Passport No: ..... ABHA ID: .....

Date of Birth: DD MM YYYY Gender: ☐ M ☐ F ☐ O Marital Status: ☐ Single ☐ Married

Occupation: ☐ Salaried ☐ Self-Employed ☐ Others, please specify Blood Group: .....

Height: ..... Weight: ..... Relationship with the proposer: ..... Dependent: ☐ Yes ☐ No

Insured Person's Photo

Signature

V. Existing Health Cover Information

Is the insured person an existing health insurance policyholder? ☐ Yes ☐ No If yes, please give details below

Company: _____ Policy Number: _____ Date of Expiry: _____ Sum Insured: _____

Servicing TPA: _____ Last Claim Date: _____ Claimed Amount: _____ Porting ☐ Yes ☐ No

Kindly fill Annexure C if insured is porting from other insurance company to our company.
Please note that the continuity of benefits shall NOT be considered if the above question is not replied in the affirmative, details are not provided and Portability Form (Annexure C) and relevant supporting documents are not submitted to UIIC.

V. Medical Information

Medical History of the person proposed for Insurance. Tick Yes/No. Please do not leave the spaces blank.

Are you suffering from HIV/AIDS Y N

If Yes, please enclose a recent certificate of our current CD4 count within last 30 days

Current CD 4 count

Has your CD4 Count gone below 500 in the past 4 years? Y N

If Yes, a) when …… B) How many times?

Do you suffer from any other illness/ disease related to/ arising of/ associated to HIV/AIDS?

If Yes, please give details:

Do you suffer from any disability as per the listed conditions mentioned below:

1. Blindness	Y N	2. Muscular Dystrophy	Y N
3. Low vision	Y N	4. Chronic Neurological conditions	Y N
5. Leprosy Cured persons	Y N	6. Specific Learning Disabilities	Y N
7. Hearing Impairment (deaf and hard of hearing)	Y N	8. Multiple Sclerosis	Y N
9. Locomotor Disability	Y N	10. Speech and Language disability	Y N
11. Dwarfism	Y N	12. Thalassemia	Y N
13. Intellectual Disability	Y N	14. Haemophilia	Y N
15. Mental Illness	Y N	16. Sickle Cell disease	Y N
17. Autism spectrum disorder	Y N	18. Multiple Disabilities including deaf/ blindness	Y N
19. Cerebral Palsy	Y N	20. Acid Attack victim	Y N
21. Parkinson's disease	Y N		

If Yes, please enclose Disability certificate mentioning percentage of disability wherever applicable

Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above? Y N

If Yes, please specify details and the number of years you are suffering below.

Do you have any other physical disability arising out of any illness / disease condition? Please specify below. Y N

Has the person who is proposed for insurance ever suffered from/is suffering from any of the following: Please tick wherever applicable and provide details in the table below.

Any other Genetic Disorders	Y N
Diabetes Mellitus, Hypertension	Y N
Any other Blood Disorder or Venereal Diseases	Y N
Diseases of Cardiovascular system, Heart diseases	Y N
Disease of Prostate/Fistula, Piles, Hernia, Varicose Veins	Y N
Disease of bones/joint including arthritis, rheumatic pain, slipped disc, spinal disorder, injury to ligaments or paralysis	Y N
Any other Nervous Disorders, Epilepsy	Y N
Any disorder/disease of the stomach, intestine, liver, gall bladder, pancreas, kidney, urinary bladder, urinary tract	Y N
Tumour, Cancer, Pre-cancerous lesion, ulcer, boil, cyst or wound etc. which does not heal or improve despite treatment	Y N
Cataract and other diseases of the eye	Y N
ENT Diseases, Respiratory or allergic disease	Y N
Gynaecological disorder such as DUB, Fibroid Uterus, Prolapsed Uterus, Ovarian cyst – or have undergone caesarean/Hysterectomy	Y N
Thyroiditis/Goitre	Y N
Any other illness, disease, accident or surgery/operation sustained?	Y N

If you answered 'Yes' to any of the prior questions, please give details in the table below. Additionally, also submit Annexure A, B.

Illness	Date of Last Consultation (DD/MM/YYYY)	Treatment Undergone	Name of the treating Doctor	Hospital Name & Phone No.	Present Status

Past Proposals

Has any proposal for life, health or critical illness insurance for any of the persons proposed to be insured ever been declined, postponed, loaded or made subject to any special conditions by any insurance company? ☐ Yes ☐ No

VI. Optional Covers

Do you want to opt for the optional cover - 'Waiver of Co-Payment'? (Additional premium applicable) Y N

VII. Payment and Bank Account Details

Premium Amount (₹): _____ (in words) _____

Premium Payment Modes: ☐ Cash ☐ Cheque ☐ DD ☐ Credit/Debit Card ☐ ECS Cheque/DD No.: _____ Date: DD/MM/YYYY

VIII. Bank Details for Processing of Refund

Bank Name: _____ Branch Address: _____

Bank Account No: _____ IFS Code: _____

Would you like to receive your insurance policy document in physical form, in addition to the electronic copy? ☐ Yes ☐ No

VIII. Declarations

☐ 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 behalf of these other persons.

☐ 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 insurer and that the policy will come into force only after requisite receipt.

☐ I further declare that I will notify in writing of any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before the communication of the risk acceptance by the company.

☐ I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured/proposer has been made to underwrite the proposal and/or claim settlement.

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

☐ Ayushman Bharat Health Account (ABHA) Declaration: I authorize the company to access my/our information as available in my/ our Ayushman Bharat Health Account (ABHA) including the medical records for the sole purpose of proposal underwriting and/or claims settlement and share the same with TPAs, Service Provider(s) of UIIC and/or any Governmental and/or Regulatory authority and/or to comply with the applicable Law/ Regulations.

I also confirm that the source of funds for premium paid under this policy is legal.

Date: DD/MM/YYYY Place: _____ Signature of the Proposer: _____

Name of the Proposer (in BLOCK letters): _____

IX. Certificate from Proposer in case Proposal form is not filled by them/The proposer signs in vernacular language/is illiterate

The proposal form is filled up by my representative, but the contents of the documents have been fully explained to me and I am willing to accept the coverage subject to terms, conditions and exceptions prescribed by the Insurance Company therein.

Date: DD/MM/YYYY Place: Signature of the Representative:

Name of the representative (in BLOCK letters):

Please note that this should necessarily be signed by the proposer and not by his/her representative.

X. Declaration of the Intermediary

I/We confirm that I/We have explained the product features to the proposer and its suitability to him/her and other insured persons.

Date: DD/MM/YYYY Place: Signature of Intermediary:

XI. Statutory Warning (Section 41 of Insurance Act, 1938 – 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 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.
- Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

XII. Office Use Only

Gross Premium: Premium for Optional Covers:

Net Premium:

Intermediary Code: Development Officer Code:

Issuing Office Code:

Issuing Office Address:

XIII. Documents Required (Please refer to Annexure D for list on what constitute as valid documents)

Please ensure all the following documents are attached along with the completed proposal form.

☐ Valid Certificate of Disability (if applicable)

☐ Proof of Age

☐ Proof of Residence

☐ Proof of Age

☐ Photocopies of all previous health insurance policies and endorsements, if applicable

☐ CD4/T-Cell Test (if applicable)

☐ 2 Stamp size photographs, one of which to be pasted in Section IV

☐ Pre-Policy Check-up Reports, if applicable

☐ PAN Details (in case PAN not available, Form 60 or 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted)

Acknowledgement by the Company

Date: DD/MM/YYYY

We acknowledge the receipt of your proposal and amount by Cash/Cheque/Others of amount of

Rs. dated DD/MM/YYYY

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions, and we shall have no liability to make any payment if premium is not received by us in full and in time or is not realized. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.

This Annexure is to be completed by EACH insured person who has answered 'Yes' to any of the questions in Section V (Medical Information) or has any pre-existing conditions/adverse history in respect of any illness.

Name of Insured Person: _____

Diabetes Questionnaire

- Date of 1st Diagnosis of Diabetes : _____
- Do you take any anti-diabetic drugs? If so, please give name with dosage : _____
- Please give details of fasting and postprandial blood sugar readings, E.C.G. findings & other investigation reports with date. Please also send reports : _____
- Please state whether you have been diagnosed with any complication of diabetes? : _____

Hypertension Questionnaire

- Date of 1st Diagnosis of Hypertension : _____
- What is your blood pressure reading? Please state with dates : _____
- Please state names of anti-hypertensive drugs with dosage details : _____
- Are you a smoker? : _____
- Is it essential/secondary/malignant hypertension? : _____
- Please state whether you have been diagnosed with any complication of hypertension? : _____
- Please give findings of all investigation reports : _____

Chest Pain or Coronary Insufficiency or Myocardial Infarction Questionnaire

- Date of 1st Diagnosis Did you ever suffer from chest pain/coronary insufficiency/myocardial infarction? If so, please give diagnosis and date. : _____
- Please state the name and dose of drugs you are taking at present : _____
- 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 form. : _____
- Please state the date of hospitalisation and names of hospitals (attach last discharge summary) : _____
- Please state complications and other related disease, if suffered. : _____
- Please state whether you can do your regular work and whether you have any limitation of activity? : _____
- Are you advised any special treatment? If so, please give information : _____

Any other Pre-Existing Condition

- Nature of illness/disease/injury & treatment received : _____
- Date of 1st Diagnosis : _____
- Whether fully cured? : _____
- Please state the date of hospitalisation and names of hospitals. (attach last discharge summary) : _____

Date: DD/MM/YYYY Place: _____ Signature of Insured Person: _____

This Annexure is to be completed by the consulting physician/surgeon if ANY of the insured persons have answered 'Yes' to any of the questions in Section V (Medical Information) or have any pre-existing conditions/adverse history in respect of any illness.

- Name of the Insured Person :

History

- Present complaints and investigation, if any? :
- Any past history of disease, operations, accidents, investigations with date, major medical complaints of hospitalisation? :
- Details of present and past medication with duration :
- Is he/she cured of diseases, if any? When was your treatment, if any, given, stopped? :
- General Examination :
- Systematic Examination :

Signature of Consulting Physician **Signature of Proposer**

Name of Consulting Physician: **Place:**

Qualifications: **Date:** DD/MM/YYYY

Address:

Telephone No:

Office Use Only

Do you consider the risk acceptable?

Competent Authority:

At Operating Office:

At Regional Office (If referred to RO):

This Annexure is to be completed by the policyholder who is porting from a health insurance policy issued by another insurance company

Name of Policyholder: _____

Policy No: _____

PORTABILITY FORM

1.	**Name of the Policyholder/ Insured (s)**	
2.	**Date of Birth / Age**	
3.	**Address of the Policyholder / Insured**	
4.	**Details of Existing Insurer**	
	a. Name of insurance company	
	b. Name of the product	
	c. Sum Insured	
	d. Cumulative Bonus	
	e. Add-ons/riders taken	
	f. Policy Number	
5.	**Details of the Proposed Insurance**	
	a. Name of the product proposed/intended to take	
	b. Sum Insured proposed	
	c. Whether Cumulative Bonus to be converted to an enhanced sum insured	
6.	**Reason(s) for Portability**	
7.	**No. of family members to be included in the policy to be ported**	
Enclosure: Photocopy of the existing & previous policy documents		
Date: **Signature of the Policyholder**		

- Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy? (Please indicate Yes / NO):

  _____

- If Yes, please give written consent to the declaration below:

I am aware that the waiting period for the following disease(s)/treatment(s) is more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s).

Name of the Disease / Treatment	Waiting Period in Days / Years
1. 2. 3. 4.	

Date: DD/MM/YYYY Place: _____ Signature of Policyholder: _____

This Annexure details the list of documents that are required along with this proposal form and the documents that are considered as valid.

Documents Required

- Completed Proposal Form
- Cancelled Cheque (supporting bank account details)
- Stamp Size Photograph (2 no.) for each insured person
- Pre-Policy Check-up reports (if applicable)
- Copy of existing health insurance policies (if applicable)
- Proof of Identity (any one document listed below)
- Proof of Residence (any one document listed below)
- PAN Details (In case PAN not available, Form 60 or 61 as per Rule 114B of the Income-Tax Rule, 1962 must be submitted)

Documentary Proof

Features	Documents
Proof of Identity	i. Passport ii. PAN Card iii. Voter's Identity Card iv. Driving License v. Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer vi. Aadhaar Card vii. Job card issued by NREGA duly signed by an officer of the State Government
Proof of Residence	i. Passport ii. Driving License iii. Aadhaar Card iv. Voter's Identity Card v. Job card issued by NREGA duly signed by an officer of the State Government vi. Letter issued by National Population Register containing details of name and address Where the above documents do not have the updated address, the following documents shall be deemed to be valid documents for the purpose of Proof of Residence. i. Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone, piped gas, water bill) ii. Property or Municipal Tax receipt iii. Pension or family pension payment orders (PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address iv. Current Photo Passbook with details of permanent/present residence address (updated up to the previous month) v. Current statement of bank account with details of permanent/present residence address (as downloaded) vi. Ration card vii. Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof viii. Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)
Proofs of both Identity and Residence	Written confirmation from the banks where the proposer is a customer, regarding identification and proof of residence