

Base Cover	<input type="checkbox"/> Section B (Cancer 360 degree Indemnity Cover)	<input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 180 Days
	<input type="checkbox"/> Section C (Hospital Cash)	
Optional Benefit	<input type="checkbox"/> Wellsurance Benefit	<input type="checkbox"/> Classic <input type="checkbox"/> Supreme <input type="checkbox"/> Elite

Please note: Sum Insured is on Individual Basis.

Policy Plan Option	Section A (Critical Illness)	Section B (Cancer 360 degree Indemnity Cover)	Section C (Hospital Cash)
<i>Insured Person</i>	<i>Sum Insured (in Rs): 5 Lakhs to 2 Cr (in multiples of 5 Lakhs)</i>	<i>Sum Insured(In Rs): 5 Lakhs to 2 Cr in multiples of 5 Lakhs</i>	<i>Sum Insured (in Rs): 500 to Rs. 20,000 (in multiples of 500's) per day for 30/60/180 days</i>
1			
2			
3			
4			
5			
6			
7			

3. DETAILS OF THE PROPOSED PERSON(S) TO BE INSURED

Sr. No	Name of the Proposed Insured Person	Height	Weight	Relationship with Proposer	Gender	Date of Birth	ABHA Number (14 digits)^^
1		(cms)	(Kgs)		M / F	dd/mm/yyyy	
2		(cms)	(Kgs)		M / F	dd/mm/yyyy	
3		(cms)	(Kgs)		M / F	dd/mm/yyyy	
4		(cms)	(Kgs)		M / F	dd/mm/yyyy	
5		(cms)	(Kgs)		M / F	dd/mm/yyyy	
6		(cms)	(Kgs)		M / F	dd/mm/yyyy	
7		(cms)	(Kgs)		M / F	dd/mm/yyyy	

^^Note: If ABHA Number is not available, we urge you to visit <https://abdm.gov.in/> for creation of ABHA ID and inform the same to us once created.

4. NOMINEE DETAILS

Details/Particulars	Nominee 1	Nominee 2
Date of Birth*		
Relationship		
Present Address of the Nominee		
Permanent Address of the Nominee	<input type="checkbox"/> If same as Present Address, please tick here	<input type="checkbox"/> If same as Present Address, please tick here
Mobile		
Email ID		
Percentage Share for Claim Amount Payable		
Bank Details of the Nominee		
Name of the account holder		
Name of the bank		
Branch Bank		
Account no.		

Bank IFSC code		
Account Type	<input type="checkbox"/> SB Account <input type="checkbox"/> Current Account <input type="checkbox"/> Others (please specify)	<input type="checkbox"/> SB Account <input type="checkbox"/> Current Account <input type="checkbox"/> Others (please specify)

Appointee details

Appointee Name	Relationship	Address of the Appointee

5. EXISTING/PREVIOUS INSURER DETAILS

Is the proposer or any of the persons proposed, already Insured under a health plan with TATA AIG General Insurance Company Ltd. or any other insurer or is a proposal pending for Policy issuance?

If yes, please indicate the Policy/Application number(s):

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Since when continuously insured:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Do you want Us to consider these details for portability* Yes No

**In case of portability, please fill up IRDAI portability form. Please note that continuity of benefits shall NOT be considered if the details are not provided. You need to approach at least 45 days prior to your expiry date to avoid any break in coverage. Please submit previous 4 years insurance policy copies. Portability is subject to IRDAI portability guidelines.*

Policy No.	Name of Proposed Insured person	Insurer	Period of Insurance		Sum Insured & Cumulative bonus / (Rs)	Deductible (Rs.)	Claims lodged during the preceding years along with the diagnosis
			From	To			
			DD/MM/YYYY	DD/MM/YYYY			
			DD/MM/YYYY	DD/MM/YYYY			
			DD/MM/YYYY	DD/MM/YYYY			

6. MEDICAL AND LIFESTYLE DETAILS

A. Medical History :

Please answer the below mentioned questions individually in Yes (Y) / No (N):

You must answer the questions truthfully. Not doing so would lead to termination of your policy.

Please answer each of the following questions individually for each Insured Person by ticking the relevant box.	Proposed Insured Person						
	1	2	3	4	5	6	7
Have you or any of the persons proposed for insurance, ever suffered from or taken treatment, or hospitalized for or have been recommended to take investigations / medication / surgery or undergone a surgery for the following medical conditions?							
<input type="checkbox"/> Decline Disease Name	<<Disease Name>>	<<Disease Name>>	<<Disease Name>>	<<Disease Name>>	<<Disease Name>>	<<Disease Name>>	<<Disease Name>>
Any other illness/disease/injury/disability in the past other than for childbirth, flu or for minor injuries that have completely healed?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Are you or any persons proposed on regular medication (including any Ayurvedic treatment) or Hospitalized for any illness/ surgery or awaiting any procedure/treatment?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Have you ever been diagnosed with any of these medical conditions with or without any follow-up tests/medications?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
<input type="checkbox"/> Elevated Blood Sugar	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
<input type="checkbox"/> Type 2 Diabetes Mellitus	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
<input type="checkbox"/> Elevated Blood Pressure/ Hypertension	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
<input type="checkbox"/> High Cholesterol	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
<input type="checkbox"/> Asthma	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Is any of the proposed insured pregnant currently? If yes, please mention expected date of delivery (EDD). Any history of pregnancy related complications?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Has any application for life, Health or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Has any health or life insurance policy ever been terminated in the past?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Have you or any members ever been diagnosed with Thyroid Disorder? If yes, please provide details for follow-up tests/ medications.	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Do you have any signs, symptoms, illness or injury including knee joint ligament tear or back pain/ Swelling or Pain in any part of body / Breathlessness on mild effort / dizziness more than once in last 6 months for which medical consultation / treatment / investigation has been required.	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Have you undergone any annual health check-up or routine medical examination in the past which showed any significant finding/s? If yes, please provide details for findings or results.	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Have you or any of your immediate family members (spouse, parents, children, parents in law) ever been diagnosed with cancer, heart attack, or stroke, prior to age 60?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

B. Detailed information in case any of the questions in section A is ticked 'Yes'.

(Please send us medical documents along with this proposal form)

Name and details of Illness (for questions answered as Yes in Section A & B above)	Diagnosis as per documents	Diagnosis date	Date of last consultation	Treatment details	Name of Surgery or procedure/ Medicines	Doctor/Hospital Name and Phone No.
Proposed Insured Person 1						
Proposed Insured Person 2						
Proposed Insured Person 3						

C. Lifestyle Information

Does any person proposed to be insured smoke or consume gutka/pan masala or alcohol. If yes please indicate the name and quantity per day.	Proposed Insured Person						
	1	2	3	4	5	6	7
Alcohol (ml) Per day <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Occasionally <input type="checkbox"/>							
Smoke (No. Cigarette/Bidis) Per day <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Occasionally <input type="checkbox"/>							
Pan Masala/Tobacco (Grams) Per day <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Occasionally <input type="checkbox"/>							
Others habit forming substances/addictives Per day <input type="checkbox"/> Per week <input type="checkbox"/> Per month <input type="checkbox"/> Occasionally <input type="checkbox"/>							

7. PAYMENT DETAILS

Name of the Premium Payer:

(if different from proposer)

Relationship with the proposer:

(if different from proposer)

Premium Amount (in Rs):

Direct Debit Authorization

Instrument type: Cash Cheque Debit Card Credit Card Others

Sources of funds: Salary Business Other _____

Please make a Crossed Cheque/DD/Pay Order in favour of 'TATA AIG General Insurance Company Limited' only.

I/We authorize Bank, to debit my account through ECS (Debit) clearing / Direct debit (Standing instruction) for Auto Renewal of the policy.

AML guidelines:

1. I/we hereby confirm that all premiums paid / payable in future will be from bonafide sources and not paid out of proceeds of crime and that such premiums are not disproportionate to my/our income. I / we understand that the Company has the right to call for documents to establish sources of funds and to cancel the insurance policy in case I / we are found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering law in India.
 2. I / we are not Politically Exposed Persons ** nor are their close relatives / family members / associates . I / we shall keep the company informed if we subsequently become a Politically Exposed Person / close relative / family member / associate of Politically Exposed Persons.
- ***"Politically Exposed Persons" shall have the meaning assigned to it under Prevention of Money-Laundering (Maintenance of Records) Amendment Rules, 2023 as amended from time to time.

Type of Organization

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Corporations | <input type="checkbox"/> Governments | <input type="checkbox"/> Non Governmental Organizations |
| <input type="checkbox"/> Society | <input type="checkbox"/> Trust | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> International Organization | <input type="checkbox"/> Cooperatives | <input type="checkbox"/> Section 8 Company |

Signature of Proposer: _____

Date: _____

8. BANK DETAILS (REQUIRED FOR REFUND/CLAIMS)

As per Regulatory requirements, we can effect payment of refund / claims only through Electronic Clearing System (ECS) / National Electronics Funds Transfer (NEFT) / Real Time Gross Settlement (RGTS) / Interbank Mobile Payment Service (IMPS)
 For this purpose please submit the following details of the insured's bank account.*

Name of the Account Holder	
Name of the Bank	
Branch Bank	
Account No.	
Bank IFSC Code	
Account Type	<input type="checkbox"/> SB Account <input type="checkbox"/> Current Account <input type="checkbox"/> Others (please specify)

Please fill an auto debit form for deduction of amount towards premium payment from bank account.

If the premium cheque is not paid from the above mentioned account then a cancelled cheque leaf of the above mentioned Account is to be attached.

#mandatory if annualized premium is more than Rs 10,000

9. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- 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 full payment of the premium chargeable.
- I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before 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 for the purpose of underwriting 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.
- I have understood the purpose of Aadhar authentication and hereby state that I have no objection in providing my Aadhar details.
- Ayushman Bharat Health Account (ABHA) Declaration: I on behalf of all proposed insured person(s) provide consent to access the medical and personal records/details [of all proposed insured person(s)], as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider(s) of TATA AIG General Insurance Company Ltd and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations

13. FOR OFFICE USE ONLY

Branch Receipt Date: _____ Intermediary Code and Name: _____

Branch Receipt Date: _____ Channel Type: _____

Business type: Urban Rural Social Customer ID: _____

Tata AIG Office Code: _____

TATA AIG General Insurance Company Limited.

Insurance is the subject matter of the solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale.
Tata AIG General Insurance Company Limited.

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