

Smart Health Critical Illness Insurance Policy - Proposal Form

We would like to inform you that Bharti AXA General Insurance has merged with ICICI Lombard General Insurance. Enjoy our seamless services while exploring our enhanced offerings and diverse non-life insurance solutions.

Important Note

Issuance of this form is not to be taken as admission of liability. Please fill this form in **Block Letters** and **Tick the Boxes** where appropriate. Please answer all questions completely and do not leave any blanks: in case any question is not relevant, please mention "Not applicable"; The insurance is not effective until the proposal is accepted and premium received.

1 Intermediary details

Intermediary/Sales Officer Name	<input type="text"/>	Code	<input type="text"/>
Branch Name	<input type="text"/>	Code	<input type="text"/>
Sales Manager's Name	<input type="text"/>	Code	<input type="text"/>
Campaign Name	<input type="text"/>	Code	<input type="text"/>
Initiative Code	<input type="text"/>	Business Indicator	<input type="text"/>
Rural Indicator	<input type="checkbox"/> Yes <input type="checkbox"/> No		

2 Proposer's details

Name	Mr. / Mrs. / Ms. / Dr.	<input type="text"/>
Profession or Occupation	<input type="text"/>	
Communication (Postal) Address	<input type="text"/>	
	Pin code	State
Contact Nos.	Mobile No.	Office +91
Residence	+91	E-mail ID

3 Details of insured person(s) (the person(s) to be insured)

Sl. No.	Name	Gender	Height	Weight	Date of Birth	Sum Insured Opted	Relationship with the Proposer	Occupation/ Profession	Nationality
1.		M/F/T			DD/MM/YYYY				
2.		M/F/T			DD/MM/YYYY				
3.		M/F/T			DD/MM/YYYY				
4.		M/F/T			DD/MM/YYYY				

M(Male), F (Female), T (Third Gender)

4 Nominee details

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. Nominee for any of the persons proposed to be insured shall be the Proposer.

Nominee Name	Relationship	Address of the Nominee

Name and Address of appointee if the nominee in minor _____

5 Medical and Life Style Information

a. Has the insured or any of the insured person(s) ever suffered/currently suffering from any disease/illness/injuries/pain/symptoms. Yes No

b. Has the insured or any of the insured person(s) ever been under any regular medication (self/prescribed)? Yes No

c. Undertaken any lab/blood tests, imaging tests viz. scans/MRI/CT in the last 5 years other than routine health check-up or pre-employment check-up? Yes No

d. Is any of the insured/insured members currently pregnant? Yes No

If yes, please mention the expected date of delivery _____

Please provide details _____

Have any person proposed to be insured received any advice/ treatment / consultation for any medical condition. Yes No
If yes, please specify details of Illness/ Medicine/Test/Surgery/Injury below:

Insured Name	Name of Pre-Existing Diseases/ Illness/ Surgery	Diagnosis Date	Date of last consultation	Treatment Inpatient / Outpatient	Doctor/Hospital Name & Phone No.
		DD/M M/YYYY	DD/M M/YYYY		
		DD/M M/YYYY	DD/M M/YYYY		
		DD/M M/YYYY	DD/M M/YYYY		
		DD/M M/YYYY	DD/M M/YYYY		

Does any person proposed to be Insured smoke or consume gutkha/ Pan Masala /alcohol? If yes, please indicate the name and quantity per week	Smoke	Alcohol	Pan Masala	Others
Insured 1:				
Insured 2:				
Insured 3:				
Insured 4:				

6 Family doctor's details

Name

Contact Nos. Mobile No.

Clinic/Hospital/Nursing Home No. +91

7 Plan details

Please Tick against the plan / sum insured.

(Please refer to our Plan Benefits for various coverage options available)

Type of Plan - Reimbursement Benefit

Sum Insured - 2,00,000 3,00,000 5,00,000

** Applicable for Insured Person (self) only

Period of insurance: From AM/PM To AM/PM

*Applicable only where medical examination is stated to be not required by the Company.

In case medical examination is to be done, the policy shall commence on or after the date of approval by underwriter or the date of receipt of premium by the Company, whichever is later

8 Existing / Previous Insurance details

Is the proposer or the persons proposed, already insured under a plan with Us or any other insurance company? If yes, please share below the Policy/ Application number(s). Please mention application number in case of pending proposal.

Do you want that these details should be considered for portability or continuity? Yes No

Name of the Insurer	Policy / Application No.	Period of Insurance												Sum Insured	Claims lodged/Paid	Cumulative Bonus				
		From Date						To Date												
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y			
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y			
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y			
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y			

9 Payment Details

Kindly select one Cheque D.D./P.O. Cash Credit/Debit card Net Banking

Cheque/D.D./P.O. no. Dated

Bank Name

Premium Amount Rs.

In words _____

10 Bank Details of the Insured (In case of any dues from the company, the amount will be credited to this bank account)

Bank Name

Account Number

IFSC Code

Branch Name & Address

11 Declaration

Please let us know if the below statement is applicable to you :

"Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations or important political party officials." Yes No

I/We 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/We am/are authorized to propose on behalf of these other persons.

I understand the information provided by me will form the basis of insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.

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

I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/ proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and / or claim settlement.

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

Data Privacy Notice:

I/We hereby provide consent to the Company for collecting/retaining any information relating to Me/Us including Sensitive Personal Information ("hereinafter cumulatively referred to as "INFORMATION"), that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION for servicing the Insurance policy obtained by Me/Us and for same may share the INFORMATION with any reinsurer, insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) engaged by the Company for servicing the Insurance policy, underwriting the risk, settlement of claim etc. without obtaining our specific consent for such sharing and we hereby provide our consent to Company for same.

I/We understand that whenever I/We would like to update/correct the INFORMATION, we will intimate the Company for the same, so as to enable the Company to amend/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same in writing and also understand that, in the event of such withdrawal by Me/Us, the Company reserves the right to not provide Me/Us the Services for which it has sought the INFORMATION.

Date: _____

Place: _____

Signature of the Proposer

12 Prohibition of rebates (section 41) of the Insurance Act 1938

- 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 or 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 Insurer.
- Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

13 For office use only

1. Whether medical test required? Yes No

Test advice date given by the underwriter

If yes, please mention date of medical examination

2. Whether proposal has been approved? Yes No

a. If yes,

i. Please indicate premium _____

ii. Date of approval

iii. Period of Insurance _____

iv. Special conditions, if any _____

b. If no, please mention the reason for not accepting the proposal _____

Name of Underwriter

Signature of Underwriter

Employee Number

For more details on risk factors and terms & conditions, please read the sales brochure carefully before concluding a sale. PF/CI/THINQ/08-15. Insurance is the subject matter of solicitation.