



**redefining /
general insurance**

**Bharti AXA General Insurance
Company Limited**

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Universal Protection Insurance Policy - Enrollment Form

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". • This form is applicable for Individuals only. • Please fill in separate form for each of the family member. • The Insurance is not effective until the proposal is accepted and premium received.

1. Intermediary Details

Name _____ Code _____
Branch _____ Code _____
Sales Manager's Name _____ Code _____

2. Customer Information (To be filled in block capitals)

Loan Account No. (LAN) _____ Customer ID _____ Proposer's Name _____
Address _____ Fixed Line Contact No. _____
Fax No. _____ Mobile No. _____ Email ID _____ Gender _____ Date of Birth _____
Nationality _____ Indian / others. In case of others, please specify _____ Pan No. _____ UID Aadhaar No. _____
Status of Proposer _____ Main applicant / Co-applicant _____ Source Of Funds Salary Business Other _____
Occupation _____ Salaries / Self-employed _____ Loan Tenure 1-5 yrs 5-10yrs 11-20 yrs 20 yrs and above _____
Sanction Date / Amount _____ Disbursal Date/Amount _____ Type of Loan _____ Policy Tenure 1 Yr / 2 yrs/ 3yrs/4yrs / 5yrs _____
Sum Insured _____ Name of the Bank / Financial Institution _____ Proposed Policy period: From _____ To _____
(Must be on or later than Instrument date/ premium payment date)

3. Premium Payment Details

Cheque Demand Draft Credit Card Cash

Instrument Number (Cheque or DD) _____ Date _____ Bank Name _____ Branch _____

Amount (In Figures and Words) _____

Please make a Crossed Cheque/DD/Pay Order in favour of 'Bharti AXA General Insurance Company Limited' only. *PAN Card copy is Mandatory for premium of Rs.50,000 and above accepted in Cash/DD or Rs. 1,00,000 and above by Chq/Credit/Debit Card Payment to be collected only from Proposer's Card / Bank Account

4. Proposer's Bank Details (In case of any dues from the company, the amount will be credited to this bank account)

Name of the Bank Account Holder _____

Bank Account No. _____ Account Type _____

Name of the Bank / Branch _____ MICR Code _____ IFSC Code _____

5. Sum Insured Opted/Nominee Details

Personal Accident	Critical Illness	Loss of Job	Fire & Allied Peril - Building	Fire & Allied Peril - Content	Burglary or House breaking - Content
_____	_____	_____	_____	_____	_____

Nominee Name: _____ Relationship with the Nominee _____ Contact No. _____

Section I. Critical Illness

Plan Opted - Plan A / Plan B / Plan C / Plan D / Plan E

Sr. No.	Name	DOB	Relationship to the proposer	Nominee	Nominee Relationship	Occupation	Sum Insured

6. Medical History:

Section A: Please answer the below mentioned questions individually in Yes(Y)/No (N). If the answer to any of the questions is yes, please provide complete details in the table for additional medical information. You must answer the questions truthfully. Not doing so may affect your coverage in case of a Claim and may lead to cancellation / termination of the Policy

Please answer each of the following questions individually for each Insured Person by ticking the relevant box.		Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6
		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
1	Have you suffered from or are you currently suffering from any disease, illness, disability, injury or accident or advised/consuming medication or undergone/advised/awaiting any surgical procedure (other than Normal /assisted Delivery or Caesarean section without any complication) or undergone any investigations, in the past 4 years?						
2	Have you ever had or has a doctor ever said that you have any of the following conditions / diseases :- High blood pressure, diabetes or sugar, any heart related ailment, brain stroke, Paralysis, TB or asthma or breathing problem, tumor or cancer, liver or gall bladder diseases, prostate, kidney or stone diseases, arthritis or bone disease, blood diseases or disorders, ulcer or stomach disorder, eye or ENT disease, dizziness or fits, HIV/AIDS / any other sexually transmitted disease, Ulcer (Stomach / Intestine), Anaemia, Leukaemia or any other blood/lymphatic system disorder						
3	Have you ever had or has a doctor ever said that you have multiple sclerosis, epilepsy, tremors, paralysis, psychiatric/mental illnesses or sleep disorder						
4	Have you or any other member(s) proposed to be insured taken any medication for more than 2 weeks in last 5 years?						
5	Have any of the females proposed to be insured currently suffering from or have ever suffered from Dysfunctional uterine bleeding, Fibroid, Cyst / Fibroadenoma or any other Gynaecological / Breast disorder?						
6	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?						
7	Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?						

Section B: Detailed information in case any of the questions in section A is ticked 'Yes': Name and details of Illness/ Medicine/Test/Surgery

Name of Insured	Diagnosis / Diagnosis date	Treatment completed / Under treatment / Left incomplete treatment (Please mention duration since completely recovered)/ Date of last consultation	Treatment inpatient /outpatient	Treatment Medical/Surgical/ Name of Surgery or procedure/ Name of medicines	Doctor/Hospital Name and Phone No.
Insured Person 1					
Insured Person 2					
Insured Person 3					
Insured Person 4					

Section C: Does any person proposed to be Insured smoke or consume Gutka/ Pan Masala /alcohol in the last 12 months? If yes, please indicate the name and quantity per week

	Smoke (No of Sticks)	Alcohol (No of pegs / Beer Bottles) (Each Peg is 30 ml)	Pan Masala (No of Pouches)	Others
Insured 1:				

Section II. Personal Accident

Sr. No.	Name	DOB	Relationship	Nominee	Nominee Relationship	Sum Insured

Section III : Involuntary Loss of Job

Name and Address of the employer

Date of Joining

Employment Basis

Permanent / Contract

Sum Insured

3 EMI of applied loan

