Photograph

UNITED INDIA INSURANCE COMPANY LIMITED REGISTERED & HEAD OFFICE: 24, WHITES ROAD, CHENNAI-600014 DIVISIONAL / BRANCH OFFICE......

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 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 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.
- f) Please fill up the proposal form completely. If space is insufficient, separate sheet may be attached wherever required.

PROPOSER DETAILS 1. Name of the proposer ••••• (Surname) (Name) 2. Residential Address and Telephone No Occupation (Profession/Occupation/ 3. Trade/ or Business) Name of Office & Address Monthly Income 4. 5. Income-Tax PAN No. 6. Name of the Medical Practitioner, his qualifications & Telephone no. if any Medical Practitioner's Regn. No.

Details of Insured Persons and their specimen signatures

Total number of Persons to be covered (in figures):

7.

(in words):

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

Photo	ographs of Insure	ed persons:			
	Photograph	Photograph	Photograph	Photograph	Photograph
8.	Do you wish to	have Policy on	: Indiv	idual basis or Famil	ly Floater basis
9.	(pl.refer to Pro	ater basis, choose a ospectus for definition under separate polic Self, spouse and cl Parents	on of family. Parer cy)	nts have	
	Indicate option	:A / B / C / D / E /	F/G/H		
10	If on Individual	basis, indicate opti	on for each indivic	lual person	
	1	Self	- A / B	3/C/D/E/F/G	i / H
	2	Spouse -	A / B	3/C/D/E/F/G	i / H
	3	Child -1-		3/C/D/E/F/G	
	4			3/C/D/E/F/G	
	5			3/C/D/E/F/G	
	6		A / B	3/C/D/E/F/G	i / H
11.	Period of Insu	rance From nsured persons at p	То		(midnight)
I	I <u>Under any oth</u> Type (Cancer II Or other Medic (A) Give particular	nsurance, Hospitalistal Insurance), If so,	ring policy as well		
Insu	rer Policy No.	Expiry dat	te Sum Insure (RS.)	ed Pre existing Diseases, if any	
II	without bro Under any Medi (IMP: A brief)	overage which has seak or within grace factorial expenses Reimbore giving details of your evaluation of you	period bursement Schem of the Scheme wil	e: YES/NO	
	a. Scheme Name o Others	the following - (stri e Provided by : of the Employer : : s covered :	Employer / C		d for coverage
	~.	, 6070, 50	under this po or only some pe	olicy	, 101 cc 3
	-	es reimbursed : nounts		ation / Only Specifie	d Diseases
Λ					

Names of the persons covered under the Scheme	Eligible Reimbursement amount	Remarks

13 Claim amounts received/receivable in preceding five years including expiring policy/Reimbursement Scheme. In case of persons not covered under any Policy or Scheme, the details of hospitalisation for the last five years may be provided -

Name of the	<u>Policy</u>	<u>Period</u>	<u>Illness</u>	<u>Claimed</u>	<u>Amount</u>	<u>TPA, if</u>
<u>Insurer / _</u>	<u>No./</u>	<u>of</u> _		<u>amount</u>	settled/pend	<u>applicable</u>
<u>Reimbursement</u>	<u>Scheme</u>	<u>Hospitali</u>			<u>ing for</u>	
<u>Provider</u>	<u>Name</u>	<u>sation</u>			<u>settlement</u>	

- 14. Has any Proposal for this Insurance or any other health insurance been refused Or cancelled or higher premium charged. If so give details:
- 15.1 Are all the insured persons are in good health and free from Physical and mental diseases or infirmity Or medical complaints?
- 15.2 If not in good health give full details

S.N.	Name of the insured persons	Nature of illness / disease injury and treatment received	Name of attending medical practitioner, surgeon with his address and Telephone No.	Whether fully cured
1. 2. 3.				

	insured persons	treatment received	-	surgeon with address and Tele No.	his phone	cured
1.						
2.						
3.						
16	Are there	any additional facts	affecting			
16	Are there	any additional facts	affecting			

the proposed insurance which should

be disclosed to Insurers? -----

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.
- 1.I/We 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.
- 2. 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- 3. I/We further declare that I/we 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.
- 4. 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.
- 5. I/We authorize the company to share information pertaining to my personal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and

I have used the Ducerston and an william to assent the assent to the to the	erms,
I have read the Prospectus and am willing to accept the coverage subject to the to conditions and exceptions stated therein and expressed in the Policy.	
Signature / / /	
Place:	
PLACE:	
DATE: Signature of the proposer	

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 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 continuing a policy except any rebate as may be allowed in accordance with the published prospectus or tables of the insurer.

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