Photograph

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

#### 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 4. Monthly Income 5. Income-Tax PAN No. 6. Name of the Medical Practitioner, his qualifications & Telephone no. if any Medical Practitioner's Regn. No. 7. Total number of Persons to be covered (in figures):

# Details of Insured Persons and their specimen signature

(in words):

| S.No | Name of        | Date of | Age | Sex | Relation | Nominee | Nominee      | Signature |
|------|----------------|---------|-----|-----|----------|---------|--------------|-----------|
|      | Insured Person | Birth   |     |     |          |         | relationship |           |
| 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<br>ospectus for definition<br>under separate polic<br>Self, spouse and cl<br>Parents   | on of family. Parer<br>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<br>nsured persons at p   | То  |                                  | (midnight)       |
| I     | I <u>Under any oth</u><br>Type (Cancer II<br>Or other Medic<br>(A) Give particular | nsurance, Hospitalistal Insurance), If so,  | ring policy as well                                   |                                  |                  |
| Insu  | rer Policy No.   | Expiry dat  | te Sum Insure<br>(RS.)                                | ed Pre existing Diseases, if any |                  |
|       |  |   |   |                                  |                  |
|       |  |   |   |                                  |                  |
| II    | without bro<br><b>Under any Medi</b><br>(IMP: A brief)                             | overage which has seak or within grace factorial expenses Reimbore giving details of your evaluation of you | period<br><b>bursement Schem</b><br>of the Scheme wil | e: YES/NO                        |                  |
|       | a. Scheme<br>Name o<br>Others  | the following - (stri<br>e Provided by :<br>of the Employer :<br>:<br>s covered :                           | Employer / C  |                                  | d for coverage   |
|       | <b>~.</b>  | , 6070, 50  | under this po<br>or<br>only some pe                   | olicy                            | , 101 cc 3       |
|       | -  | es reimbursed :<br>nounts   |   | ation / Only Specifie            | d Diseases       |
| Λ     |  |   |   |                                  |                  |

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

13 <u>Claim amounts received/receivable in preceding five years including expiring</u> 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 | Nature of illness / | First     | Name of attending |           | Whether |
|------|---------|---------------------|-----------|-------------------|-----------|---------|
|      | the     | disease injury and  | diagnosed | medical           |           | fully   |
|      | insured | treatment           |           | practitioner,     | Treatment | cured   |
|      | persons | received            |           | surgeon with his  | taken     |         |
|      |         |                     |           | address and       |           |         |
|      |         |                     |           | Telephone No.     |           |         |
| 1.   |         |                     |           |                   |           |         |
| 2.   |         |                     |           |                   |           |         |
| 3.   |         |                     |           |                   |           |         |

|                | persons                                  | received |  | surgeon<br>address<br>Telephor | with his and | taken | cureu |
|----------------|--|----------|--|--------------------------------|--------------|-------|-------|
| 1.<br>2.<br>3. |  |          |  |                                |              |       |       |
| 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.

- 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 with any Governmental and/or Regulatory authority.

|           | d the Prospectus and am willing t<br>and exceptions stated therein and ex | to accept the coverage subject to the terms, opposite to the Policy. |
|-----------|---|--|
| Signature |   | Date//   |
| Place:    |   |  |
| PLACE:    |   |  |
| DATE:     |   | Signature of the proposer  |

# Section 41 OF INSURANCE ACT 1938

#### > PROHIBITION OF REBATES <

- (1) 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.
- (2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to five hundred rupees.