THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI - 400 001.

ATMANIRBHAR HEALTH POLICY, THE NEW INDIA ASSURANCE CO LTD

PROPOSAL FORM

URN: (NIA/Health/22-23/AH)

GUIDELINES FOR COMPLETION OF THE FORM

- This policy is specially designed for Persons with Disability, Mental Illness and Persons with HIV/AIDS.
- Persons with Disability shall be covered if 40% or more disability is certified by the Medical Board appointed by the government for certifying Disability as per the Disability Act 2016.
- Please answer all questions correctly and completely.
- Information for fields marked with asterisk (*) are mandatory.
- Only Indian Nationals can be covered under this policy.
- Only one policy can be purchased for this product across all insurers.
- Note: The Coverage proposed for insurance is not covered until the proposal is accepted and premium is paid and the same is realized by The New India Assurance Co Ltd.

Intermediary Details

Intermediary Name	
Intermediary Code	
Intermediary Contact Details	

Proposer Details*:

Name		
Communication Address		
	City:	State:
	Pin-code:	Landmark:
Contact Details	Phone	Email
Profession:	Salaried ☐ Self-Employed ☐ Other ☐ Details :_____	
Occupation and Nature of Business / Work:		
PAN No. / form 60 / 61		
AADHAAR No.	× × × × × × × ×	
Date of Birth		
Gender	Male ☐ Female ☐ Other ☐	

Coverage Details:

Policy Type	Individual Basis
Policy period	1 year
Period of Insurance	From DD/MM/YYYY to DD/MM/YYYY
Sum Insured	400000 ☐ 500000 ☐
Coverage opted:	Pre-existing HIV/AIDS ☐ Pre-existing Disability ☐ Pre-existing HIV/AIDS and Disability ☐
Waiver of Co-payment opted	Yes ☐ No ☐

Details of Persons to be Insured:

Name of the Insured	
Nationality	
Date of Birth	
Age	
Gender	M / F / O
Height	
Weight	
Occupation	
Marital Status	
Relation with Proposer	

***#ABHA NUMBER/ABHA ID** (14 digits)-

 # Note-Disclosing the ABHA ID in this form will not absolve the Proposer/Members from Disclosure of all Material Facts relating to this Insurance.

***Ayushman Bharat Health Account (ABHA) Declaration :** I/We provide my / our consent to access my / our (all insured) medical and personal records / details, 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 The New India Assurance 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.

Category of Disability or Illness (Refer below List):

Category 1 : (Yes/No_____) Category 2 : (Yes/No_____) Category 3 : (Yes/No_____)

Please mention the Type of Disability/Illness :_____

Category 1	Category 2	Category 3
Blindness	Low vision	Muscular Dystrophy
Leprosy Cured persons	Specific Learning Disabilities	Chronic Neurological conditions
Hearing Impairment (deaf and hardof hearing)	Intellectual Disability	Multiple Sclerosis
Speech and Language disability	Haemophilia	Locomotor Disability
Dwarfism	Autism spectrum disorder	Thalassemia
	Acid Attack victim	Mental Illness
	Parkinson's disease	Sickle Cell disease
		Multiple Disabilities including deaf / blindness
		Cerebral Palsy
		HIV/AIDS

Nominee Details:

Sr. No.	NAME	Relation	Date of Birth	Appointee Name* (If the Nominee is minor)	Relationship with Minor (Nominee)	% Share nominee is entitled to*

Where Nominee is a minor, give the details of Appointee. If only one nominee is mentioned insurer will consider his/her share is 100%

Previous / Existing Health Details of Insured:

Do you suffer from HIV/AIDS?	Yes/No	If Yes, please enclose a recent certificate of your current CD4 count (within past 30 days)
Current CD 4 count		
Has your CD4 Count gone below 500 in the past 4 years?	Yes/ No If yes when and How many times _____	
Do you suffer from any other illness/disease related to/arising of/associated to HIV/AIDS?	Yes /No	If Yes, please give details:
Do you suffer from any disability as per the listed conditions mentioned below:	Yes/ No	If Yes, please enclose Disability certificate mentioning percentage of disability wherever applicable.

1. Blindness ☐	2. Muscular Dystrophy ☐
3. Low vision ☐	4. Chronic Neurological conditions ☐
5. Leprosy Cured persons ☐	6. Specific Learning Disabilities ☐
7. Hearing Impairment (deaf and hard of hearing) ☐	8. Multiple Sclerosis ☐
9. Locomotor Disability ☐	10. Speech and Language disability ☐
11. Dwarfism ☐	12. Thalassemia ☐
13. Intellectual Disability ☐	14. Haemophilia ☐
15. Mental Illness ☐	16. Sickle Cell disease ☐
17. Autism spectrum disorder ☐	18. Multiple Disabilities including deaf / blindness ☐
19. Cerebral Palsy ☐	20. Acid Attack victim ☐
21. Parkinson's disease ☐	

Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above?
Yes ☐ No ☐
If Yes, please specify details and the number of years you are suffering : _____

Do you have any other physical disability arising out of any illness/disease condition ?_____

Any other previous medical details _____

Previous/Existing Health Insurance details

Policy No. / Application No.	Insurer Name	Period of Insurance (from - to)	Sum Insured	Claims lodged during the preceding years
Do you have the same policy from any one or other insurer? Yes ☐ No ☐ **If yes, please share details below:**				
Policy No. / Application No.	**Insurer Name**	**Period of Insurance (from - to)**	**Sum Insured**	**Claims lodged during thepreceding years**

Electronic Insurance Account Details Section:

I want _____related information in - Physical Format - Yes/No e-Format (electronic) as & when applicable - Yes/No
Choose your Insurance Repository (For those selecting e-Format) (a) NSDL Data Management Ltd. (b) CDSL Insurance Repository Ltd (c) Karvy Insurance Repository Ltd. (d) CAMS Repository Services Ltd
I have e Insurance Account & the No. is _____
My CKYC No. (Central Know Your Customer registry number) is (If available) _____

Premium Payment Details

Name of Premium payer:	
Premium Payment Frequency :	Monthly / Quarterly / Half Yearly
Premium Amount (in INR)	
Instrument Type:	Cash / Cheque / Debit Card / Credit Card / Others: Please Specify : _____
Date (DD/MM/YYYY):	Cheque No.:
Bank Name :	Bank Account Number :
IFSC Code :	Branch Name :

Bank Account Details For Process Of Refund

Cheque will be issued in the name of the Proposer only.

In case of cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account: (Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly.

Name of Account holder	
Cheque No	
Bank Name	
Branch Name	
Cheque Date	
Cheque Amount for	
Name as in Bank Account	
Bank Account No	
IFSC Code	
MICR Code	

Note: The Proposer agrees and undertakes to intimate in writing to <<Name of Insurance Company>> about any change in bank account details.

If ECS is selected, please submit the standing instruction form available at our branches.

Place:

Date: DD/MM/YYYY Signature of proposer:_____

AML Guidelines

I / We hereby confirm that all premiums have been / will be paid from bonafide sources and no premiums have been / will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002. I/We understand that the Company has the right to call for documents to establish source of funds. The insurance Company has the right to cancel the insurance contract in case I am/ have been found guilty by any competent court of law under any statues, directly or indirectly governing the prevention of money laundering in India.

Please Tick ☐ if you wish to receive the physical copy.

By Default Policy documents shall be shared to your Registered Email ID.

Agent's Declaration

I,_____(Full Name) in my capacity as an Insurance Advisor / Specified Person of the Corporate Agent / Authorised employee of the Broker / Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non- disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

Date : _____ Signature of Agent :_____

Place : _____ Licence No. :_____

Declaration & Warranty on behalf of all Persons Proposed to be Insured

i. I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements 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.

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

iii. 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.

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

v. 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.

vi. I/We aware of premium loading, (if any declared above) for habit's & diseases as declared / mention by me/ us above.

vii. I/ We hereby agree to keep record of KYC details of all the individual members covered under the group insurance, and ensure to provide the details of beneficiaries to the Company as and when required.

Vernacular Declaration

** Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language. (Note: The below must be witnessed by someone other than the Advisor/Employee of the Company).

I/We certify that the product applied for by me/us and the contents of the Proposal Form have been clearly explained to me/us and I/we have fully understood them. I/We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/us. I, (Full name of the witness)_____(Relation with the Proposer)_____ adult and inhabitant of (city) _____and residing at _____

_____

do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the insurance policy from The New India Assurance Co Ltd., to the Proposer and he/she/they have understood the same. I/we declare that whatever I/we have stated herein above is true and correct to the best of knowledge and belief.

Date : DD MM YYYY

Place :_____

Signature of the Witness Signature/Thumb impression of the Proposer

Photograph of the Insured person

SECTION 41 OF INSURANCE ACT, 1938

As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited, as follows:

(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 or risk relating to lives or property in India, any rebate of 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 published prospectuses 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 Rupees Ten Lakhs.

NEFT details

Mandatory details required to process all payment due in relation to your policy including refunds (if any) and/or claims directly to your Bank account.

I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy:

Bank account details as provided below and for which I am submitting a cancelled cheque, should be used by the company for electronic fund transfer as mode of payment.(cancelled cheque should be of the same bank account in which the refund needs to be credited directly)

Particulars of Bank account:

Name(As in Bank Account)	
Name of the Bank	
Name of Branch	
Bank Account Number	
MICR No	
IFSC Code	

I agree and undertake to initiate in writing to **The New India Assurance Company Ltd** about any change in the bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

Proposer/Policy holder's signature:

Date:

DISCLAIMER: **The New India Assurance Company Ltd.** Shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation – failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder.

Aforesaid NEFT transactions shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. **The New India Assurance Company Ltd** shall be indemnified against any loss/damages/claims caused to **The New India Assurance Company Ltd** in carrying out your aforesaid NEFT instructions.

Instructions

- It is important for these electronic payment systems that the policy Holder's name in the Policy must be exactly match with the name in the Bank Account records/details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required
- The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFSC Code, which is applicable to NEFT only.(a number allotted to each participating bank branch) of the branch where the funds need to be transferred.
- Cancelled cheque should be attached along with the NEFT format.
- In case of cancelled bank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required.
- NEFT Form needs complete in all respect.