

AROGYA SANJEEVANI POLICY, MAGMA HDI GENERAL INSURANCE COMPANY LIMITED - PROPOSAL FORM



Proposal No. _____

| 1. FOR OFFICE USE ONLY | | | |
|------------------------|--|---|--|
| Branch Name | | Branch Code | |
| Intermediary Name | | Intermediary Code | |
| Sales channel Type | | If POSP then please provide the below:- | |
| | | a) PAN Card Number of POSP | |
| | | b) AADHAR Card Number of POSP | |
| Proposal Received On | | | |

GUIDELINES FOR COMPLETION OF THE FORM (TO BE FILLED BY PROPOSER)

Please answer all the questions fully and correctly. This proposal will be the basis of any insurance policy that We may issue. You must disclose all facts relevant to all persons proposed to be insured that may affect Our decision to issue a policy or its price, terms, conditions and exclusions. The policy shall become void at Our sole discretion, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the Proposer or any one acting on his behalf.

If there is insufficient space for you to provide information whether as requested or otherwise, please attach a separate sheet. If you are in any doubt, please seek the help of Our company representative or your insurance advisor. If We accept a proposal for insurance, it shall be subject to the Policy terms and conditions and We shall have no liability to make any payment under the Policy if premium is not received by Us in full and in time, or is not realized or non-fulfillment of pre-policy medical check-up or proposal is not accepted by Us.

All fields/details marked with * are mandatory.

2. PROPOSER DETAILS

Please fill up this form in CAPITAL LETTERS for yourself and each proposed insured person.

| | | | |
|---|--|---|---|
| Proposer Name* (Mr./Ms./Mrs./Other) | (First Name) | (Middle Name) | (Last Name) |
| Marital Status | <input type="checkbox"/> Single | <input type="checkbox"/> Married | |
| Gender | <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> None of these |
| Nationality* | Date of Birth* <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | |
| Occupation | <input type="checkbox"/> Salaried | <input type="checkbox"/> Self-employed | <input type="checkbox"/> Professional <input type="checkbox"/> Others (please specify)..... |
| Annual Income (in ₹) | <input type="checkbox"/> < 3,00,000 | <input type="checkbox"/> 3,00,000 – 10,00,000 | <input type="checkbox"/> 10,00,001 – 25,00,000 <input type="checkbox"/> >25,00,000 |
| Address for Correspondence* | | | |
| Landmark | | | |
| City: | | State: | Pin Code: |
| Phone No. STD Code | <input type="text"/> | Landline No. | <input type="text"/> |
| | | Mobile No.* | <input type="text"/> |
| Email ID | <input type="text"/> | | |
| Are you a Magma Employee? <input type="checkbox"/> Yes, Employee Code..... <input type="checkbox"/> No Do you have any other Policy with Magma HDI? <input type="checkbox"/> Yes, Policy No:..... <input type="checkbox"/> No | | | |
| Do you wish to receive policy wording and other documents by E-mail Only? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| PAN No.* <input type="text"/> | | Aadhaar No. <input type="text"/> | |
| ID Proof Type* | <input type="checkbox"/> PAN Card <input type="checkbox"/> Passport <input type="checkbox"/> Voter ID Card <input type="checkbox"/> Driving License <input type="checkbox"/> Aadhaar Card <input type="checkbox"/> Others If others, please specify _____ | | |

* Mandatory if premium under this proposal is Rs. 50,000 or more

3. PLAN DETAILS*

| | |
|---------------------------|---|
| Policy Type | <input type="checkbox"/> Individual <input type="checkbox"/> Family Floater |
| | If Family Floater*, number of persons to be covered: Adults: <input type="text"/> Children: <input type="text"/> (* - Max 4 Adults and 3 children) |
| Sum Insured | <input type="checkbox"/> 50,000 <input type="checkbox"/> 1 lakh <input type="checkbox"/> 1.5 lakhs <input type="checkbox"/> 2 lakhs <input type="checkbox"/> 2.5 lakhs <input type="checkbox"/> 3 lakhs <input type="checkbox"/> 3.5 lakhs <input type="checkbox"/> 4 lakhs <input type="checkbox"/> 4.5 lakhs <input type="checkbox"/> 5 lakhs <input type="checkbox"/> 5.5 lakhs <input type="checkbox"/> 6 lakhs <input type="checkbox"/> 6.5 lakhs <input type="checkbox"/> 7 lakhs <input type="checkbox"/> 7.5 lakhs <input type="checkbox"/> 8 lakhs <input type="checkbox"/> 8.5 lakhs <input type="checkbox"/> 9 lakhs <input type="checkbox"/> 9.5 lakhs <input type="checkbox"/> 10 lakhs |
| Premium Payment Frequency | <input type="checkbox"/> Single Premium <input type="checkbox"/> Monthly Instalment <input type="checkbox"/> Quarterly Instalment <input type="checkbox"/> Semi-annual Instalment |
| Period of Insurance | <input type="checkbox"/> 1 Year |

4. DETAILS OF INSURED PERSONS TO BE COVERED

| Details | Insured Person 1 | Insured Person 2 | Insured Person 3 | Insured Person 4 | Insured Person 5 | Insured Person 6 | Insured Person 7 |
|---|------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| Title | | | | | | | |
| Name* | (First Name) | | | | | | |
| | (Middle Name) | | | | | | |
| | (Last Name) | | | | | | |
| Gender (Male/Female/None of these) | | | | | | | |
| Height* (cm) | | | | | | | |
| Weight* (kg) | | | | | | | |
| Eye Refractive Error Index (Left and Right Eye) | | | | | | | |
| Date of Birth* (DD/MM/YYYY) | | | | | | | |
| Relationship with Proposer* | | | | | | | |
| Occupation (Salaried/Self-employed/Professional/Others) | | | | | | | |
| ABHA No | | | | | | | |

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5. NOMINATION

Policyholder is the nominee for all Insured members. Below details are for nominee to Policyholder.

| | | | |
|----------------------------|------------------------|--------|------|
| Name of Nominee | First | Middle | Last |
| Relationship with Proposer | Date of Birth DDMMYYYY | | |
| Contact Number of Nominee | | | |

If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

| | | |
|----------------|---------------------------|-----------------------------|
| Appointee Name | Relationship with Nominee | Contact Number of Appointee |
| | | |

6. EXISTING/PREVIOUS INSURANCE DETAILS

Is the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma HDI General Insurance Company Limited or any other insurance company? Yes No

If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.)

Since when are you continuously insured?: DDMMYYYY

| Insured Person Name (First, Middle, Last) | Insurer Name | Date of Joining | Policy No./ Application No. | Period of Insurance | | Sum Insured (₹) | Claims details, if any |
|--|--------------|-----------------|--------------------------------|---------------------|----|-----------------|------------------------|
| | | | | From | To | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

If you want to avail the portability benefit from your existing insurance policy, please also submit to us portability form (as an annexure to this proposal form) and all the policy documents relating to the existing policy in addition to the information given above.

7. MEDICAL AND LIFESTYLE INFORMATION*

| SECTION A: Have any of the person proposed to be insured ever suffered from/are suffering from any of the following?: Please tick "YES" for insured person wherever applicable and provide details in Section B. | Insured Person 1 | Insured Person 2 | Insured Person 3 | Insured Person 4 | Insured Person 5 | Insured Person 6 | Insured Person 7 |
|--|------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| 1. Hypertension History (Y/N) | | | | | | | |
| a) Duration | | | | | | | |
| b) Medication | | | | | | | |
| c) Dosage | | | | | | | |
| 2. Diabetes Mellitus History (Y/N) | | | | | | | |
| a) Type 1 or Type 2 | | | | | | | |
| b) Duration | | | | | | | |
| c) Medication | | | | | | | |
| d) Dosage | | | | | | | |

| | Yes/No | Insured Person No. |
|--|--------|--------------------|
| 3. Heart and Circulatory Conditions/Disorders: Chest pain, angina, high cholesterol/lipids, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, thrombosis, blood disorders, etc. | | |
| 4. Urinary Conditions/Disorders: Blood in urine, urinary frequency, painful/difficult urination, Kidney and/or Bladder infections, stones of urinary system, renal failure, dialysis or any other Kidney/Urinary Tract or Prostate Disease | | |
| 5. Musculoskeletal Conditions/Disorders: Joint/back pain, Arthritis, Spondylosis, Joint Replacement or any other Disorder of muscles/bones/joints/ligaments, tendons or discs, gout, herniated disc, amputation/prosthesis | | |
| 6. Respiratory Conditions/Disorders: Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), chronic cough, coughing of blood, etc. or any Other Lung/Respiratory Disease | | |
| 7. Digestive Conditions/Disorders: Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder or any other Gastro Intestinal condition | | |
| 8. Cancer/Tumor: Benign or Malignant tumor, any Growth/Cyst, any Cancer | | |
| 9. Brain/Nervous System/Psychiatric Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any other Brain/Nervous System Disease, Mental/Psychiatric disorder | | |
| 10. Female Reproductive Conditions/Disorders: Pelvic pain, abnormal menstrual bleeding, abnormal PAP smear, endometriosis, Fibroid, Cyst/Fibroadenoma, Bleeding Disorder, Pelvic infection or any other Gynecological/Breast cysts/lumps/tumor | | |
| 11. Is any female person proposed to be insured pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? | | |
| 12. Metabolic and Endocrine Conditions/Disorders: Adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, any autoimmune/genetic disorder | | |
| 13. Does the person proposed to be insured suffer from any chronic or long-term medical condition, or have any other disability, abnormality or recurrent illness or injury or unable to perform normal activities? | | |
| 14. Does the person proposed to be insured use tobacco products/cigarettes or drinks alcohol? | | |
| 15. Does any of the person proposed to be insured suffers from any infertility related condition? | | |
| 16. Has any person proposed to be insured consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s)/any psychiatric condition/undergone any hospitalization/illness/surgery/currently taking medication(s) for any condition or medical procedures (including diagnostic testing)? | | |
| 17. Have you or any of the persons proposed to be insured been diagnosed with or undergone surgery for any of the following Critical Illnesses, prior to proposing for this cover - Cancer, Heart Attack, Coronary Artery, Bypass Graft, Heart Valve Replacement/Repair, Coma, Kidney Failure, Stroke, any Transplant, Paralysis, Multiple Sclerosis, Motor Neurone Disease or HIV/AIDS? | | |

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2. Authorization for electronic policy fulfillment and service communications (Please read carefully and put a check mark against each before signing)

I hereby consent that the policy documents may be sent to me by email at _____ (Please provide us your e-mail id) or via sms at my mobile no. provided above" can be added to all proposal forms.

I hereby consent to and authorize Magma HDI General Insurance Company Limited (" Company") to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of Company from time to time and subject to the provisions of applicable law.

I wish to get all policy related communications on My WhatsApp number

Whatsapp Number: _____

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Place: _____

Name of Proposer: _____

Signature of the Proposer: _____

3. Vernacular Declaration

I hereby declare that I have fully explained the contents of the proposal form and all other documents incidental to availing the health insurance from Magma HDI General Insurance Company Limited to the proposer in the language understood by him/her. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the proposer. Replies have been read out to, fully understood and confirmed by the proposer.

Declarant's Name: _____

Relationship with proposer: _____

Signature of declarant: _____

Signature of applicant in vernacular: _____

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

4. Intermediary Declaration

I, _____ (Full Name) in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/Authorized 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 responses(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, or 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 premium paid under the Policy may be forfeited to the Company.

License No./ID (Advisor/Corporate Agent/Broker/Relationship Officer)

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Signature of the Insurance Advisor: _____

I [name of proposer] confirm that I have understood all the features/benefits available under this Policy.

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Signature of the Proposer: _____

5. Proposer Declaration

(Certification where for any reason, the proposal and other connected papers are not filled in by the Proposer).

The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract. The Proposal Form is filled by _____ under my instruction and I found it to be correct.

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Signature of the Proposer: _____

6. AML Guidelines

1. I/we hereby confirm that all premiums paid / payable in future are from bonafide sources and not paid out of proceeds of crime and that such premiums are not disproportionate to my/our income. I / we understand that the Company has the right to call for documents to establish sources of funds and to cancel the insurance policy in case I / we are found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering law in India.

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Signature of the Proposer: _____

Are you or any of the proposal applicants PEPs* or a close relative/associate of PEPs*? Yes No

If yes, please share the details of "Politically Exposed Persons" (PEPs):

*(PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials.

2. Additional Information:

Nationality: Indian Non-Indian If, Non-Indian, please specify Country: -----

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3. **Type of Organisation:** (Applicable where an organisation is the proposer. In case of proposer being Individual, Sole Proprietor or HUF, please select option X)
- (i) Corporations (ii) Trust (iii) Government (iv) Partnership / LLP (v) Non-Government Organisations
(vi) Co-operatives (vii) Society (viii) Private Limited Company (ix) Public Limited Company (x) others, please specify-----
4. **Source of Funds for premium payment:** :
Business: ----- Salaried: ----- Others (please specify) -----

11. GENERAL INFORMATION

1. Caution

You are obliged to make a full and frank disclosure of all facts material to the assumption of risk in relation to you and every person proposed to be insured that would influence Our decision to issue the policy or the terms on which it is issued and you must not misrepresent any information to Us. The obligation continues until the policy is issued and does not end with the submission of this proposal form. If, therefore, there is any change in the information given herein or new information comes to light before the policy is issued, then you must inform Us of the same in writing without delay. If there is insufficient space to provide additional information, whether as requested or otherwise, then please attach an extra sheet duly signed. If the disclosure obligations are breached then such breach may render any policy issued void.

Prohibition of Rebates Under Section 41 of Insurance Law (Amendment) Act, 2015

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 part of the commission payable or any rebate of the premium shown on the policy nor shall any person taking out or continuing the policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.
2. If any person fails to comply with sub-regulation (1) above, he shall be liable to payment of a fine which may extend to Ten Lakh Rupees.

Acknowledgment

Proposal No. _____

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

We acknowledge with thanks the receipt of your proposal and amount by Cash/Cheque/NEFT/Demand Draft/ Others _____ of amount of Rs. _____ dated _____ drawn on _____. Neither the submission to Us of a completed proposal for Insurance nor any payment for any policy sought obliges Us to agree to issue a policy, which decision is and always shall be in Our sole and absolute discretion. If We accept a proposal for Insurance, it shall be subject to the policy terms and conditions and We shall have no liability whatsoever if premium is not received by Us in full and in time or is not realized. If We do not accept the proposal, We will inform you and refund the payment after deducting the charges for pre-policy health checkup, if any, received from you without interest.

Signature of the receiver and office seal _____

Terms and Conditions :

- Initial waiting period of 30 days for all Illnesses (except Hospitalization due to Injury)
- Specific waiting period of first two years/ 4 years for specific Illnesses and treatments (mentioned in the Policy wording)
- Pre- Existing Diseases declared and accepted by Us will be covered immediately after 4 years of continuous coverage under the Policy
- Sum Insured can be increased at the time of Renewal only. The Company reserves right to approve/ reject the increase in Sum Insured. Increased Sum Insured amount will be subject to fresh waiting period.
- Factors determining the Renewal premium are (i) age slab of the senior most Insured Person at the time of Renewal (ii) any change in the Renewing Policy.
- The liability of the Company does not commence until this Proposal has been accepted by the Company and premium is realized.

Magma HDI General Insurance Co. Ltd. | www.magmahdi.com | E-mail: customercare@magmahdi.co.in | Toll-free no. : 1800 2663202 | Registered Office: Development House, 24 Park Street, Kolkata – 700016. CIN: U66000WB2009PLC136327 | IRDAI Reg. No. 149 | Trade Logo displayed above belongs to Magma Ventures Private Limited and HDI Global SE and is used by Magma HDI General Insurance Company Limited, under license.