

# THE ORIENTAL INSURANCE COMPANY LIMITED, HEAD OFFICE: A-25/27, ASAF ALI ROAD, NEW DELHI 110002

#### **HAPPY FAMILY FLOATER POLICY**

#### PROPOSAL FORM

- i. PROPOSAL FORM AND SELF DECLARATION FORM TO BE FILLED IN BLOCK LETTERS AND IN DUPLICATE.
- ii. PLEASE ATTACH TWO STAMP SIZE PHOTOGRAPHS OF EACH INSURED PERSON.
- iii. THE COMPANY WILL NOT BE ON RISK UNTIL THE PROPOSAL HAS BEEN ACCEPTED BY THE COMPANY AND COMMUNICATION OF THE ACCEPTANCE HAS BEEN MADE TO THE PROPOSER IN WRITING ON RECEIVING FULL PAYMENT OF PREMIUM.
- IV ANY PERSON BEYOND 60 YEARS OF AGE DESIRING TO TAKE INSURANCE COVER HAS TO UNDERGO PRE INSURANCE HEALTH CHECK UP THROUGH COMPANY'S LISTED DIAGNOSTIC CENTRE AND 50% OF THE COST OF SUCH EXPENSES TO BE REIMBURSED BY THE COMPANY AFTER ACCEPTANCE.

1. NAME OF THE INSURED PERSON AND RELATIONSHIP WITH THE PROPOSER

S No 1.	Name of the insured	Relation ship with Proposer	Sex M/F	Whether dependa nt on the proposer Y / N	Date of Birth	Age (in complete d years)	Occupation	Sum Insured for family (Rs)
2.						<b>†</b>		1
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4.								
5.								
6.								
7.								

#### 2. PLAN OPTED:

S.No.		Sum Insured							
	Silver					Gold			opted for P.A.
	Without Add-On	With P.A.	Without Add-On	With P.A.	With Plan 'A'	With Plan 'B'	With Plan 'A'+P.A.	With Plan 'B'+P.A.	1
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No 1.	Name of the insured Name of t					of th	e Ir	sui	rer					Type of policy (Pleas specify) P.A., Cancer, Mediclaim, others)		eas ncer,	Policy		Polic				
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### DECLARATIONS:

FROM

, To

1. I hereby 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 am 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 further declare that I 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 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 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.

Place	Signature of Proposer.	
Date	Name of Proposer	

#### NOTE:

Nomination

In case of death claims, the name of the beneficiary making claim, relationship with the insured and legal status is to be mentioned.

The claim for any of the insured person will be payable in the name of Proposer and discharge voucher signed by him will be considered valid. However, in the event of unfortunate demise of the Proposer during the course of policy period, the claim may be payable to the nominee declared by the Proposer in this form.

riomination				
1				
Oriental Insurance C	ompany Ltd under this po	olicy in the event of	my death	the amount payable by the
receipt shall be suffic	ient discharge to the Cor	Rela	tionship to the Insured	) and I further declare that his
Dated this	Day of	200	at	

Signature of Proposer

Signature of Witness Name and address

PROHIBITION OF REBATES (Section 41 of the Insurance Act 1938 provides)

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 renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer. Any person making default in complying with provision of this section shall be punishable with fine, which

## SELF DECLARATION FORM

(FORM TO BE DULY FILLED BY EACH APPLICANT ONLY IN DUPLICATE)

^	lame of the Insured:3. Date of birth: ge (in completed years):3. Date of birth: ddress:		_Sex:
	elephone No.:E-mail ID:		
	ntification Document Details:(Photo ID Proof / Ration Ca		
_	PERSONAL HISTORY: (For all insure	ed persons listed	in the proposal)
	PARTICULARS	YES / NO	DETAILS
dis	Are you in good health and free from physical and mental eases or infirmity or major complaints?		
illn	Have you ever suffered from any of the following diseases / esses. Please write <b>Yes</b> / <b>No</b> .		
1	Any Neurological / mental or related diseases?		
2	slipped disc or other spinal disorder or paralysis of any kind or fainting episode, blackout, fit.		
3	High blood pressure, palpitation, Heart diseases including ischaemic heart diseases, other circulatory disorders including rheumatic fever etc.		
4	Diseases of uterus, ovaries, breast or any other gynaecological disorder		
5	Fistula, Piles, Hernia, Varicose veins etc.		
6	Any disease of bones, joints, Arthritis including rheumatic diseases etc.		
7	Any respiratory diseases		
8	Any allergic diseases		
9	Any dimness of vision or cataract etc.		
	Any disease of ears or difficulty or interference with hearing etc.		
	Any disorder of the stomach, ulcer, bowel or gall bladder, kidney etc.		
12	Cancer, malignant growth, boil, cyst or wound etc.		
13	Diabetes or any urinary diseases.		
14	Genital Disorder		
	Any cerebral or vascular strokes or sudden loss of consciousness or similar disease.		
16	Tuberculosis (TB)		
17	AIDS / HIV / related disorder etc.		
18	Congenital diseases (Since Birth)		
19	(a) Have you ever suffered from dental problems? YES/NO (b) If, yes, specify same.		\$
20	(c) When were you treated last for same.  Any other complaint requiring specialist's consultation or		•
21	surgical or hospital treatment or investigations.  Any other complaint or tendency that may necessitate such consultation or treatment in the future		
2)			
B)	Have you Noticed sudden decrease or increase in your	weight in past si	x months Yes /

investigations copy):	n (Attach Copy of discharge card and decisio concentration
	of surgery or part operated Completely cured YES / NO, give details
I the Undersigned hereby decl	ard and doctor's consultation notes and investigations copy)  are that all the information given by me in this form is true and I understand and untrue on correlation with my medical test or medical examination before affect the coverage and payments of my health insurance benefit under this
Name of applicant	Signature:
Date:	Place: