Photograph

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

FAMILY MEDICARE PROPOSAL FORM

| AGENCY CODE | ANNUAL PREMIUM | POLICY NO |
|-------------|----------------|-----------|
| | | |

DEV. OFFICER CODE

IMPORTANT

- The Company will not be on risk until the proposal and Insured Persons details have been a) accepted by the Company and communication of the acceptance has been given to the proposer in writing on full payment of premium
- 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.
- Persons above 45 years of age or persons below 45 years of age, having adverse medical c) history declared in the proposal form, will have to undergo pre-acceptance health checkup at a recognised Hospital/Nursing Home/Laboratories/Clinic at the cost of insured.
- Fresh proposal form is required along with pre-acceptance medical check-up as d) 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.
- 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.

PROPOSER DETAILS

| 1. 1 | Name of the proposer | | | ••••• |
|------|---------------------------|---------------------------|----------------------|-----------|
| | | (Surname) | | (Name) |
| 2. | Address and | i) Residence | : | |
| | Telephone No | | | |
| | | ii) Office | : | |
| 3. | Total number of memb | ers to be covered (in fig | gures): | |
| (in | words): | | | |
| (S | eparate Insured Persor | n Details forms are to b | e enclosed) | |
| | | | | |
| 4. | Sum Insured Opted | : | | |
| 5. I | Do you wish to avail of t | he following additional | covers under the pol | icy: |
| | A. AMBULANCE CHARG | GES: | | |
| | B. HOSPITAL DAILY CA | ASH | | |
| | If yes, | for Rs.250/- per day / | Rs.500/- per day | |
| 6. | Period of Insurance | From | | |
| | | То | (r | nidnight) |
| SPE | ECIMEN SIGNATURE TABL | .E | | |

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

Photographs of Insured persons:

| Photograph | Photograph | Photograph | Photograph | Photograph |
|------------|------------|------------|------------|------------|
| | | | | |

- 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 | 1 | 40 | `F | ٠. |
|---|---|----|----|----|
| • | | ٦, | | ٠ |

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.

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

INSURED PERSON DETAILS

To be completed separately including Questionnaire form for each insured person (if more than one insured person required to be covered please obtain additional forms from the

POLICY NO:

INSURED PERSON No. ANNUAL PREMIUM

| COII | iipaiiy). | | | |
|---------|--|---|-----------------------|---------------------------|
| 1. | Name of the Insure | d Person : | | |
| 2. | Address | : | | |
| | | D 11.4 | | |
| | | PIN C | | |
| _ | Co. / Codler or tools | | · / U.Territory | |
| 3. | Sex (Strike out wh | | / F | |
| | | applicable) : Male | / Female | |
| 4. - | Relationship with t | • • | | |
| 5. | Date of Birth and A | | | |
| 6. | - | hly Income : Rs. | | |
| | (b) Income Tax P. | AN No. : | | |
| 7. | Profession / Occup- Business (Please de | | | |
| | With nature of duti | es) : | | |
| 8. | Name and address of Practitioner, his qu | | | |
| | & Telephone No. if | | | |
| | • | F | Pincode | |
| | Tel. No. | | | |
| 9. | Medical Practitione | r's Regn. No. : | | |
| 10. | Under any other Ins | surance, Hospitalisatio surance), If so, | • | |
| | (A) Insurer | Policy No. | Perio | od of cover |
| | (B) If current insure Please specify; | r is United India: | | |
| | (i) Policy Type | Policy No. | Office | Expiry Date |
| | without brea | ık or within grace peri under Poli | od cy No | peen renewed continuously |
| | (C) Claim amounts r | eceived / receivable i | n preceding two years | |
| | Amount (Rs.) | Illness Policy | Period Insur | rer Office |

- (a) Insurer, Policy No. and Period of cover
- (b) Claim Amt. Recd. / Receivable : Period : From: TO:
- 11. Any Proposal for this Insurance or any other similar insurance refused Or cancelled or higher premium charged. If so give details:
- 12. MEDICAL HISTORY TO BE COMPLETED BY THE PROPOSER / INSURED PERSON

PLEASE ANSWER THE FOLLOWING QUESTIONS IN YES OR NO. (A DASH IS NOT SUFFICIENT) AND GIVE FULL DETAILS IF ANSWER IS YES.

- 12.1 Are you in good health and free from Physical and mental diseases or infirmity Or medical complaints?
- 12.2 If not in good health give full details
- 13. Have you ever suffered from any of the diseases / illness? If yes, give details:
 - (a) any nervous, mental or psychiatric disease
 - (b) slipped disc or other spinal disorder (fainting episode, blackout, fit) paralysis of any kind
 - (c) high blood pressure, heart diseases, including ischaemic heart disease, other circulatory disorder etc., (rheumatic fever)
 - (d) Fistula, Piles, hernia, varicose veins
 - (e) Any disease of the bones or joints Including rheumatic disease
 - diseases of uterus, ovaries or breast or any specific gynaecological disorders
 - (g) any respiratory or allergic disease
 - (h) any disorder of the stomach, ulcer, bowel or gall bladder, kidney stones etc.,
 - any cancer, malignant growth, boil, cyst or wound etc., which does not heal or improve despite treatment
 - (j) any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations
 - (k) any complaint or tendency that may necessitate such consultation or treatment in the future
 - (l) any dimness of vision / cataract
 - (m) any disease of ears or difficulty or interference with hearing
 - (n) diabetes or any urinary diseases
 - (o) any other illness or disease or accident or operation sustained by you.
- 14. (a) Have you ever suffered from dental

problems? Yes / No

(b) If yes specify same

(c) When were you treated last for same

15. Give particulars in table below of any other illness or disease or accident or operation sustained by you in the past

| | sastamed by you in the past | | | | |
|------|-----------------------------|-----------|-------------------|-----------|---------|
| S.N. | Nature of illness / | | Name of attending | Treatment | Whether |
| | disease injury and | diagnosed | medical | taken | fully |
| | treatment received | | practitioner, | | cured |
| | | | surgeon with his | | |
| | | | address and | | |
| | | | Telephone Number | | |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4 | | | | | |

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.
- 18. Please specify sum Insured opted: Rs.

I hereby declare and warrant that the above statements are true and complete. I consent and authorise the Insurers to seek medical information from any Hospital / Medical Practitioner who has at any time attended or may attend concerning any disease or illness which affects my physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be effected. If after the insurance is effected, it is found that the statements, answers or particulars stated in the Proposal form and its questionnaires are incorrect or untrue in any respect, the Insurance Company shall incur no liability under this insurance.

I have read the Prospectus and am willing to accept the coverage subject to the terms,

| conditions and exceptions stated therein and ex | xpressed in the Policy. |
|---|--|
| Signature | Date// |
| Place: | |
| NAME OF THE PROPOSER / INSURED PERSON (IN BLOCK LETTERS) N.B: This should necessarily be signed by in proposer may sign. | nsured person. In case of minor, guardian or |
| ## FOR OFFICE USE ## Basic Premium for Scheme Premium for Additional covers opted | Rs |
| Staff Discount TO BE COMPLETED BY PROPOSER IN CASE OF AD' IN THE PROPOSAL FORM IN RESPECT OF APPLICA | |
| DIAPETES OUESTIONNIAIDE. | |

DIABETES QUESTIONNAIRE:

| 1. | Date of diagnosis of Diabetes | |
|----|---|--|
| 2. | Did you suffer from coma or procoma? | |
| 3. | Do you take any anti diabetic drugs? If so please | |
| | give names with dose. | |
| 4. | Please give details of Fasting and post prandial Blood Sugar readings, E.C.G. findings and other investigation reports with dates. Please also attach reports | |
| 5. | Do you suffer or have you suffered from any complications of diabetes or any other diseases? | |

HYPERTENSION QUESTIONNAIRE

- 1. What is your Blood Pressure reading, please state with dates?
- Please state name of antihypentensive drugs with dose
- 3. Are you a smoker?
- 4. Is it essential / secondary / Malignant Hypertension?
- 5. Please state whether you have suffered from any complications or other diseases
- 6. Please give findings of all investigation reports

CHEST PAIN OR CORONARY INSUFFICIENCY OR MYOCARDIAL INFARCTION QUESTIONNAIRE:

- 1. Did you ever suffer from chest pain or coronary insufficiency or myocardial infarction? If so give please give diagnosis and date
- 2. Please state name and doss of drugs you are taking at present
- 3. Please state the findings with dates of investigations done like ECG, stress test, coronary angiography's X-ray, pathology reports etc., Please send reports with the prescribed form.
- 4. Please state the date of hospitalisation and names of hospitals and consults

- 5. Please state complications and other diseases if suffered
- 6. Please state whether you can do your regular work and whether you have any limitation of activity?
- 7. Are you advised any special treatment? If so please give information

| PLA(DAT | | | Signature of Proposer/Insured person |
|--------------|------|---|---|
| | | | |
| | | TO BE COMPLETED BY CONSULTING P (in case of adverse Medica | |
| 1. | Nam | ne of the Insured: | |
| 2. | HIST | ORY | |
| | a) | Present complaints and investigation if any | |
| | b) | Any past history of disease, operation, | |
| | | accidents investigations with date, major med | dical complaints or hospitalisation |
| | c) | Details of present and past medication with d | uration |
| | d) | Is he cured of disease, if any? When, was your | treatment, if any, given, stopped? |
| 3. | Gen | eral Examination | |
| 4. | Syst | ematic Examination | |
| 5. | Do y | ou consider the risk acceptable | |
| _ | | re of proposer | Signature of consulting physician Name of consulting Physician: Qualifications: Address: |
| Plac Date | | | Telephone Number: |

TO BE COMPLETED BY OFFICIAL OF INSURANCE COMPANY ------

DO YOU CONSIDER THE RISK ACCEPTABLE?