THE ORIENTAL INSURANCE COMPANY LIMITED,

HEAD OFFICE: A-25/27, ASAF ALI ROAD, NEW DELHI 110002

MEDICAL INSURANCE PROPOSAL FORM

PROPOSAL FORM NO. **DATE:**

1. **FORM TO BE FILLED IN BLOCK LETTERS.**
2. **PLEASE SUBMIT TWO STAMP SIZE PHOTOGRAPHS OF EACH INSURED PERSON ALONGWITH TWO COPIES OF PROPOSAL FORM. NAME AND AGE OF THE INSURED MUST BE WRITTEN ON THE BACK OF THE PHOTO.**
3. **THE COMPANY WILL NOT BE ON RISK UNTIL THE PROPOSAL HAS BEEN ACCEPTED BY THE COMPANY AND COMMUNICATION OF THE ACCEPTANCE HAS BEEN GIVEN TO THE PROPOSER IN WRITING ON RECEIVING FULL PAYMENT OF PREMIUM.**
4. **IN CASE OF ADVERSE MEDICAL HISTORY ANNEXURE 'A' TO BE COMPLETED BY THE CONSULTING PRACTITIONER (NOT BELOW MD) AND TO BE SUBMITTED BY THE PROPOSER.**
5. **ANNEXURE 'A' IS ALSO TO BE OBTAINED FOR PERSONS AGED ABOVE 50 YEARS AND BE SUBMITTED ALONGWITH LATEST ECG PRINT OUT WITH REPORT AND FASTING BLOOD SUGAR TEST AND URINE STRIP TEST REPORT OR ANY OTHER MEDICAL REPORT REQUIRED BY THE COMPANY.**

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

S. No.	Name of the insured's / proposer	Relation ship with Proposer	Sex M/F	Date of Birth	Age	Occup ation	Sum Insure d (Rs)
1.							
2.							
3.							
4.							
5.							
6.							
7.							

2. ADDRESS & TELEPHONE NO. / MOBILE NO. / E-MAIL ADDRESS

		Mobile no
Ph.No	E-mail	

3.PERMANENT ACCOUNT NO. (ISSUED BY INCOME-TAX AUTHORITIES)

4.NAME - ADDRESS & TELEPHONE NO OF FAMILY PHYSICIAN

Ph.No	Mobile No

5.PLEASE FURNISH DETAILS OF ANY OTHER INSURANCE AT PRESENT OR PAST AND CLAIM DETAILS IN THE PAST YEARS.

S. No	First Name of the insured	Name of the Insurer	Type of policy (Please specify) P.A., Cancer, Mediclaim others)	Policy Number	Policy Period
1.					
2.					
3.					
4.					
5.					
6.					
7.					

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6.CLAIM DETAILS IF ANY OF INSURED

S.No. of Proposer	First Name of The Insured	Amount of Claim	Policy No.	Policy Period	Ailment for which amount claimed
1.					
2.					
3.					
4.					
5.					
6.					
7.					

7. PLEASE ANSWER THE FOLLOWING QUESTIONS IN YES / NO

	SERIAL NO.OF PERSON IN PARA (1)						
PARTICULARS	**1**	**2**	**3**	**4**	**5**	**6**	**7**
A. Are you in good health and free from physical and mental diseases or infirmity or major complaints ?							
B. Have you ever suffered from any of the following disease / illnesses. Please encircle the disease and write **Yes** otherwise write **No.**							
1 Any Neurological / mental or psychiatric diseases?							
2 slipped disc or other spinal disorder or paralysis of any kind or fainting episode, blackout, fit.							
3 High blood pressure, 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.							
6 Any disease of bones, joints Arthritis including rheumatic diseases etc.							
7 Any respiratory or allergic diseases							
8 Any dimness of vision or cataract etc.							
9 Any disease of ears or difficulty or interference with hearing etc.							
10 Any disorder of the stomach, ulcer, bowel or gall bladder, kidney etc.							
11 Cancer, malignant growth, boil, cyst or wound etc.							
12 Diabetes or any urinary diseases.							
13 Any cerebral or vascular strokes or similar disease.							
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 Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations.							
16 Any other complaint or tendency that may necessitate such consultation or treatment in the future							

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8. PLEASE GIVE DETAILS OF DISEASES/ ILLNESSES/INJURIES DEFORMITIES ETC DECLARED YES IN COLUMN NO. 7.

S.No	Name of the insured person									Nature of illness / disease / injury	Date when first treated	Name & Address Of attending medical practitioners	Whether fully cured
1.													
2.													
3.													
4.													
5.													
6.													
7.													

9. PLEASE STATE THE NAME OF PRE-EXISTING DISEASES / ILLNESS/ INJURIES SUFFERED / SUFFERS BY THE PROPOSER.

S.No	First Name of the insured person									Name of disease / illness /injuries.	Remarks
1.											
2.											
3.											
4.											
5.											
6.											
7.											

10. ARE THERE ANY ADDITIONAL FACTS EFFECTING THE PROPOSED INSURANCE WHICH SHOULD BE DISCLOSED TO THE INSURERS.

S.No	First Name of the insured person									Remarks
1.										
2.										
3.										
4.										
5.										
6.										
7.										

11. PLEASE GIVE THE DETAILS OF EXISTING MEDICLAIM POLICY.

S.No	First Name of the insured person									Name of the Insurer	Policy no.	Sum Insured	Period	Remarks
1.														
2.														
3.														
4.														
5.														
6.														
7.														

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12. HAS THE PROPOSAL OF ANY OF THE MEMBERS OF FAMILY PROPOSED BEEN REFUSED/ HIGHER PREMIUM CHARGED OR FACED DIFFICULTY IN SIMILAR PROPOSAL DUE TO:

S.No	First Name of the insured	Refusal by insurer	Higher premium charged on a/c of high claim ratio	Cancellation of policy by insurer
1.				
2.				
3.				
4.				
5.				
6.				
7.				

13. NAME OF THE NOMINEE IN THE EVENT OF DEATH OF INSURED DURING THE COURSE OF TREATMENT.

S.No.	First Name of the Insured	Name of the Beneficiary	Relation with Insured
1.			
2.			
3.			
4.			
5.			
6.			
7.			

14. PROPOSED DATE & PERIOD OF INSURANCE(DD MM YY)

FROM		To	

I/we declare that the statements made by me/us in this proposal form are true and to the best of my / our knowledge and belief and I/we hereby agree that this declaration shall form the basis of the contract between me/us and The Oriental Ins.Co.Ltd.. I / we also declare that if any additions or alterations are carried out after the submission of this proposal form and /or issuance of policy document, the same would be conveyed to the The Oriental Insurance Company immediately. I further consent and authorize the Oriental Insurance Company Limited and/or any of its authorized representative to seek medical information from any hospital/medical practitioner who has attended or may attend in future concerning any disease or illness. I further declared that I have read the prospectus and have understood the same. I accept the policy, subject to terms, exceptions and conditions prescribed therein and further disclose that on the event of finding any thing contrary to what has been declared by me, I shall be held responsible for all consequences thereof and insurance company shall incur no liability under this insurance.

Place		Signature of Proposer.
Date		Name of Proposer

INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATES

Section 41 of the Insurance Act 1938 provides as follows:

Any person making default in complying with provision of this section shall be punishable with fine which may extend to Rs.500/-.

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.

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ANNEXURE - A

MEDICAL CERTIFICATE
TO BE COMPLETED BY CONSULTING PHYSICIAN NOT BELOW MD.

S.No.		1.	2.	3	4.	5.	6.	7.
1.	Name of the Insured							
2.	Age							
3.	Any Past History of diseases / operations / investigation / accident / investigation with date and major complaints.							
4.	Details of past medication							
5.	Blood Pressure							
6.	Pulse							
7.	General Examination							
8.	Systemic Examination							
9.	ECG Report and observation							
10.	Blood / Urine Report							
11.	Present complaints investigation, if any.							
12.	Details of present medication.							
13.	Remarks.							

Signature of Poposer

Signature of Physician

NAME OF THE PROPOSER

Name, Address and Seal
of physician with Registration No.

Place:

Date:

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