United India Insurance Company Limited
Regd. Office: 24 Whites Road, Chennai, 600 034

Family Medicare Policy

Proposal Form

Important Instructions
(Please read the instructions below carefully before filling out this form)

- This Proposal Form shall be the basis of the policy to be issued. Thus, please provide all the information sought in this Proposal Form & all additional relevant information fully & accurately. Please do not leave any space blank or put dashes.
- 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 after full payment of premium.
- Details of up to 6 Insured Persons, including the proposer, can be filled in this Proposal Form. For additional members, please use a fresh form.
- Pre-policy health check-up reports not older than 30 days are required to be submitted in case of proposals for persons above the stipulated age or in case of enhancement of Sum Insured beyond the specified limit as explained in prospectus.
- Persons porting (switching) from health insurance policies of other non-life insurance or stand-alone health insurance companies must complete Annexure C (portability form) along with Proposal Form, Annexure A, B (if required).
- List of documents required is provided in Annexure D.

I. Proposer Details
(Please submit a copy of Aadhaar/Passport/Election Photo ID Card/Latest Electricity Bill/Bank Pass Book as Proof of Address)

Name: ____________________

Date of Birth: DD/MM/YYYY Gender: ☐ Male ☐ Female ☐ Transgender Marital Status: ☐ Single ☐ Married

Occupation: ☐ Salaried ☐ Self-Employed ☐ Others, please specify ____________

PAN Card No: ____________ Aadhaar Card/Passport No: ____________ E-Insurance Account No. ____________
(if available)

Address: ____________________

____

City: ____________ State: ____________ Pin Code: ____________

Tel. No. (with STD Code): ____________ (Home) ____________ (Mobile)

E-mail ID: ____________________

II. Nomination (Mandatory)

Nominee Name: ____________ Nominee Relationship with the Proposer: ____________

Nominee Address: ____________________

____________________ Nominee Contact No: ____________

(Nominee mentioned above is for the Proposer. For other members covered under the Policy, the proposer is deemed to be the Nominee)

III. Coverage Details (Please tick the option selected)

Policy Type: ☐ Individual Sum Insured ☐ Family Floater Is TPA Service required? ☐ Yes ☐ No

Sum Insured Options (In Rs.): ☐ 3 Lakhs ☐ 4 Lakhs ☐ 5 Lakhs ☐ 6 Lakhs ☐ 7 Lakhs ☐ 8 Lakhs ☐ 9 Lakhs ☐ 10 Lakhs
☐ 15 Lakhs ☐ 20 Lakhs ☐ 25 Lakhs

Coverage required from ________ am/pm of DD/MM/YYYY to midnight of DD/MM/YYYY

IV. Insured Person Details

No. of Persons Covered (including proposer): ________ (in figure) ____________ (in words)

Paste one stamp size photograph and sign below. In case of minor, guardian or proposer may sign.
Another stamp size copy of the same photograph is to be submitted with this proposal form, with the proposer/insured person's name written on the reverse.

Proposer Photo/Insured Person 1 Photo	*Insured Person 2 Photo*	*Insured Person 3 Photo*	*Insured Person 4 Photo*	*Insured Person 5 Photo*	*Insured Person 6 Photo*
Signature	*Signature*	*Signature*	*Signature*	*Signature*	*Signature*

All fields are mandatory. Please do not leave any field blank.

Customer Code						
Details	**Proposer / Insured Person 1**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**
Name						
Date of Birth (DD/MM/YYYY)						
AADHAAR No.						
Age						
Gender (M/F)						
Sum Insured						
Height (cm)						
Weight (kg)						
Blood Group						
Marital Status						
Relationship with Proposer						
Dependent (Y/N)						
Occupation						

Is proposer or any insured person an existing health insurance policyholder ? ☐ Yes ☐ No
If yes, please give details below:

Details	**Proposer / Insured Person 1**	**Insured Person 2**	**Insured Person 3**	**Insured Person 4**	**Insured Person 5**	**Insured Person 6**
Company						
Policy No.						
Policy Name						
Expiry Date						
Sum Insured						
Servicing TPA						
Last Claimed Date						
Claimed Amount						
Porting (Y/N)						

Kindly fill Annexure C if insured is porting from other insurance company to our company.
Please note that the continuity of benefits shall NOT be considered if the above question is not replied in the affirmative, details are not provided and Portability Form (Annexure C) and relevant supporting documents are not submitted to UIIC.

V. Medical Information

Medical History of Proposer and Insured Persons. Tick Yes/No. Please do not leave the spaces blank.

	Proposer/ Insured 1	*Insured 2*	*Insured 3*	*Insured 4*	*Insured 5*	*Insured 6*
Are/Is you/the person proposed for insurance in good health and free from physical and mental disease or infirmity or medical complaints	Y N	Y N	Y N	Y N	Y N	Y N
Have any of the persons who are proposed for insurance ever suffered from/are suffering from any of the following: Please tick wherever applicable and provide details in the table below.						
Psychiatric Disorder	Y N	Y N	Y N	Y N	Y N	Y N
Genetic Disorders	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus, Hypertension	Y N	Y N	Y N	Y N	Y N	Y N
Blood Disorder, HIV/AIDS, Venereal Diseases	Y N	Y N	Y N	Y N	Y N	Y N
Diseases of Cardiovascular system, Heart diseases	Y N	Y N	Y N	Y N	Y N	Y N
Disease of Prostate/Fistula, Piles, Hernia, Varicose Veins	Y N	Y N	Y N	Y N	Y N	Y N

Disease of bones/joint including arthritis, rheumatic pain, slipped disc, spinal disorder, injury to ligaments or paralysis	Y N	Y N	Y N	Y N	Y N	Y N
Nervous Disorders, Epilepsy	Y N	Y N	Y N	Y N	Y N	Y N
Any disorder/disease of the stomach, intestine, liver, gall bladder, pancreas, kidney, urinary bladder, urinary tract	Y N	Y N	Y N	Y N	Y N	Y N
Tumour, Cancer, Pre-cancerous lesion, ulcer, boil, cyst or wound etc. which does not heal or improve despite treatment	Y N	Y N	Y N	Y N	Y N	Y N
Cataract and other diseases of the eye	Y N	Y N	Y N	Y N	Y N	Y N
ENT Diseases, Respiratory or allergic disease	Y N	Y N	Y N	Y N	Y N	Y N
Gynaecological disorder such as DUB, Fibroid Uterus, Prolapsed Uterus, Ovarian cyst – or have undergone caesarean/Hysterectomy	Y N	Y N	Y N	Y N	Y N	Y N
Thyroiditis/Goitre	Y N	Y N	Y N	Y N	Y N	Y N
Any other illness, disease, accident or surgery/operation sustained?	Y N	Y N	Y N	Y N	Y N	Y N
Any complaint that may necessitate treatment in the future?	Y N	Y N	Y N	Y N	Y N	Y N

If you answered 'Yes' to any of the questions above, please give details in the table below. Additionally, also submit Annexure A, B.

Name of the Persons to be insured	Illness	Date of Last Consultation (DD/MM/YYYY)	Treatment Undergone	Name of the treating Doctor	Hospital Name & Phone No.	Present Status

Past Proposals

Has any proposal for life, health or critical illness insurance for any of the persons proposed to be insured ever been declined, postponed, loaded or made subject to any special conditions by any insurance company? ☐ Yes ☐ No

Pre-Policy Check-up Reports. Please tick Yes/No if the relevant documents for that test are submitted, if applicable.

The reports should not be dated more than 30 days prior to the date of proposal.

	Proposer/ Insured 1	*Insured 2*	*Insured 3*	*Insured 4*	*Insured 5*	*Insured 6*
Physical Examination	Y N	Y N	Y N	Y N	Y N	Y N
Complete Blood Count	Y N	Y N	Y N	Y N	Y N	Y N
Urine Routine and Microscopic Examination	Y N	Y N	Y N	Y N	Y N	Y N
HbA1c (Blood Sugar)	Y N	Y N	Y N	Y N	Y N	Y N
Lipid Profile	Y N	Y N	Y N	Y N	Y N	Y N
Serum Creatinine	Y N	Y N	Y N	Y N	Y N	Y N
SGOT & SGPT	Y N	Y N	Y N	Y N	Y N	Y N
ECG (Electrocardiogram)	Y N	Y N	Y N	Y N	Y N	Y N
Any other report as required by UIIC	Y N	Y N	Y N	Y N	Y N	Y N

VI. Optional Covers

(If policy is on Family Floater Basis, please tick Yes/No only for Proposer)

	Proposer/ Insured 1	*Insured 2*	*Insured 3*	*Insured 4*	*Insured 5*	*Insured 6*
Restoration of Sum Insured	Y N	Y N	Y N	Y N	Y N	Y N
Maternity Expenses and New Born Baby Cover	Y N	Y N	Y N	Y N	Y N	Y N
Daily Cash Allowance on Hospitalisation	Y N	Y N	Y N	Y N	Y N	Y N

VII. Payment and Bank Account Details

Premium Amount (₹): ____________ (in words) ________________________________

Premium Payment Modes: ☐ Cash ☐ Cheque ☐ DD ☐ Credit/Debit Card ☐ ECS

Cheque No.: ____________________ Date: DD/MM/YYYY

Credit/Debit Card No. ________________________ Card Type: ☐ Visa ☐ Master Card Expiry Date: DD/MM/YYYY

Bank Name: ____________________ Bank Account No: ____________________

VIII. Declaration

☐ I/We 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/we am/are authorized to propose on behalf of these other persons.

☒ I understand that the information provided by me will form the basis of the insurance policy and that the policy will come into force only after full receipt of the premium chargeable.

☐ I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

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

☐ 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.

I/We declare that I/We have Submitted the above proposal along with payment of ₹ __________ by Cash/vide cheque/DD No/ __________ dated drawn on __________ . I understand that the cash/cheque given is banked for operational convenience and commencement of risk is subject to the acceptance of proposal by you.

I also confirm that the source of funds for premium paid under this policy is legal.

Date: DD/MM/YYYY Place: __________ Signature of the Proposer: __________

Name of the Proposer (in BLOCK letters): ____________________

IX. Certificate from Proposer in case Proposal form is not filled by him/her

(As required to comply with clause no. 6 (4) of Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017)

The proposal form is filled up by my representative, but the contents of the documents have been fully explained to me and I am willing to accept the coverage subject to terms, conditions and exceptions prescribed by the Insurance Company therein.

Date: DD/MM/YYYY Place: __________ Signature of the Proposer: __________

Name of the Proposer (in BLOCK letters): ____________________

Please note that this should necessarily be signed by the proposer and not by his/her representative.

X. Declaration of the Intermediary

I/We confirm that I/We have explained the product features to the proposer and its suitability to him/her and other insured persons.

Date: DD/MM/YYYY Place: __________ Signature of Intermediary: __________

XI. Statutory Warning (Section 41 of Insurance Act, 1938 – Prohibition of Rebates)

- 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 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 prospectus or tables of the Insurers.
- Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

XII. Office Use Only

Gross Premium: ______________________________ Premium for Optional Covers: ______________________________

Net Premium: ______________________________

Intermediary Code: ______________________________ Development Officer Code: ______________________________

Issuing Office Code: ______________________________

Issuing Office Address: ______________________________

XIII. Documents Required (Please refer to Annexure D for list on what constitute as valid documents)

Please ensure all the following documents are attached along with the completed proposal form.

☐ ID Proof

☐ Proof of Residence

☐ Proof of Age

☐ Photocopies of all previous health insurance policies and endorsements, if applicable

☐ 2 Stamp size photographs, one of which to be pasted in Section IV

☐ Pre-Policy Check-up Reports, if applicable

☐ PAN Details (in case PAN not available, Form 60 or 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted)

Acknowledgement by the Company

Date: DD/MM/YYYY

We acknowledge the receipt of your proposal and amount by Cash/Cheque/Others ______________ of amount of

Rs. ____________________ dated DD/MM/YYYY

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 to make any payment 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 any payment received from you without interest within next 30 days.

This Annexure is to be completed by EACH insured person who has answered 'Yes' to any of the questions in Section V (Medical History) or has any pre-existing conditions/adverse history in respect of any illness.

Name of Insured Person: ________________

Diabetes Questionnaire

- Date of 1st Diagnosis of Diabetes : ________________
- Do you take any anti-diabetic drugs? If so, please give name with dosage : ________________
- Please give details of fasting and postprandial blood sugar readings, E.C.G. findings & other investigation reports with date. Please also send reports : ________________
- Please state whether you have been diagnosed with any complication of diabetes? : ________________

Hypertension Questionnaire

- Date of 1st Diagnosis of Hypertension : ________________
- What is your blood pressure reading? Please state with dates : ________________
- Please state names of anti-hypertensive drugs with dosage details : ________________
- Are you a smoker? : ________________
- Is it essential/secondary/malignant hypertension? : ________________
- Please state whether you have been diagnosed with any complication of hypertension? : ________________
- Please give findings of all investigation reports : ________________

Chest Pain or Coronary Insufficiency or Myocardial Infarction Questionnaire

- Date of 1st Diagnosis : ________________
  Did you ever suffer from chest pain/coronary insufficiency/myocardial infarction? If so, please give diagnosis and date.
- Please state the name and dose of drugs you are taking at present : ________________
- Please state the findings with dates of investigations done like ECG, Stress Test, coronary angiography, X-ray, pathology reports, etc. Please send reports with the proposal form. : ________________
- Please state the date of hospitalisation and names of hospitals (attach last discharge summary) : ________________
- Please state complications and other related disease, if suffered. : ________________
- Please state whether you can do your regular work and whether you have any limitation of activity? : ________________
- Are you advised any special treatment? If so, please give information : ________________

Any other Pre-Existing Condition

- Nature of illness/disease/injury & treatment received : ________________
- Date of 1st Diagnosis : ________________
- Whether fully cured? : ________________
- Please state the date of hospitalisation and names of hospitals. (attach last discharge summary) : ________________

Date: DD/MM/YYYY

Place:

Signature of Insured Person:

This Annexure is to be completed by the consulting physician/surgeon if ANY of the insured persons have answered 'Yes' to any of the questions in Section V (Medical History) or have any pre-existing conditions/adverse history in respect of any illness.

- Name of the Insured Person : ______________________________

History

- Present complaints and investigation, if any? : ______________________________

____

____

- Any past history of disease, operations, accidents, investigations with date, major medical complaints of hospitalisation? : ______________________________

____

____

- Details of present and past medication with duration : ______________________________

____

- Is he/she cured of diseases, if any?
When was your treatment, if any, given, stopped? : ______________________________

____

- General Examination : ______________________________
- Systematic Examination : ______________________________

Signature of Consulting Physician **Signature of Proposer**

______________________________ ______________________________

Name of Consulting Physician: **Place:** ______________________________

Qualifications: **Date:** DD/MM/YYYY

Address:

Telephone No:

Office Use Only

Do you consider the risk acceptable?

Competent Authority:

At Operating Office:

At Regional Office (If referred to RO):

This Annexure is to be completed by the policyholder who is porting from a health insurance policy issued by another insurance company

Name of Policyholder: ______________________________

Policy No: ______________________________

PORTABILITY FORM

1.	**Name of the Policyholder/ Insured (s)**	
2.	**Date of Birth / Age**	
3.	**Address of the Policyholder / Insured**	
4.	**Details of Existing Insurer**	
	a. Name of insurance company	
	b. Name of the product	
	c. Sum Insured	
	d. Cumulative Bonus	
	e. Add-ons/riders taken	
	f. Policy Number	
5.	**Details of the Proposed Insurance**	
	a. Name of the product proposed/intended to take	
	b. Sum Insured proposed	
	c. Whether Cumulative Bonus to be converted to an enhanced sum insured	
6.	**Reason(s) for Portability**	
7.	**No. of family members to be included in the policy to be ported**	
Enclosure: Photocopy of the existing & previous policy documents		
Date: **Signature of the Policyholder**		

- Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy? (Please indicate Yes / NO):

  ____

- If Yes, please give written consent to the declaration below:

I am aware that the waiting period for the following disease(s)/treatment(s) is more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s).

Name of the Disease / Treatment	Waiting Period in Days / Years
1. 2. 3. 4.	

Date: DD/MM/YYYY Place: ____________ Signature of Policyholder: ____________

This Annexure details the list of documents that are required along with this proposal form and the documents that are considered as valid.

Documents Required

- Completed Proposal Form
- Cancelled Cheque (supporting bank account details)
- Stamp Size Photograph (2 no.) for each insured person
- Pre-Policy Check-up reports (if applicable)
- Copy of existing health insurance policies (if applicable)
- Proof of Identity (any one document listed below)
- Proof of Residence (any one document listed below)
- PAN Details (In case PAN not available, Form 60 or 61 as per Rule 114B of the Income-Tax Rule, 1962 must be submitted)

Documentary Proof

Features	Documents
Proof of Identity	i. Passport ii. PAN Card iii. Voter's Identity Card iv. Driving License v. Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer vi. Aadhaar Card vii. Job card issued by NREGA duly signed by an officer of the State Government
Proof of Residence	i. Passport ii. Driving License iii. Aadhaar Card iv. Voter's Identity Card v. Job card issued by NREGA duly signed by an officer of the State Government vi. Letter issued by National Population Register containing details of name and address Where the above documents do not have the updated address, the following documents shall be deemed to be valid documents for the purpose of Proof of Residence. i. Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone, piped gas, water bill) ii. Property or Municipal Tax receipt iii. Pension or family pension payment orders (PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address iv. Current Photo Passbook with details of permanent/present residence address (updated up to the previous month) v. Current statement of bank account with details of permanent/present residence address (as downloaded) vi. Ration card vii. Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof viii. Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)
Proofs of both Identity and Residence	Written confirmation from the banks where the proposer is a customer, regarding identification and proof of residence