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

a) The Company will not be on risk until the proposal and Insured Persons details have been accepted by the Company and communication of the acceptance has been given to the proposer in writing on full payment of premium

b) 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.

c) Persons above 45 years of age or persons below 45 years of age, having adverse medical history declared in the proposal form, will have to undergo pre-acceptance health check-up at a recognised Hospital/Nursing Home/Laboratories/Clinic at the cost of insured.

d) Fresh proposal form is required along with pre-acceptance medical check-up as 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.

e) Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation 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. Name of the proposer ....
(Surname) (Name)

2. Address and i) Residence :
Telephone No
ii) Office :

3. Total number of members to be covered (in figures):
(in words):
(Separate Insured Person Details forms are to be enclosed)

4. Sum Insured Opted :

5. Do you wish to avail of the following additional covers under the policy:
A. AMBULANCE CHARGES:
B. HOSPITAL DAILY CASH
If yes, for Rs.250/- per day / Rs.500/- per day

6. Period of Insurance From
To (midnight)

SPECIMEN SIGNATURE TABLE

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

Photographs of Insured persons:

Photograph	Photograph	Photograph	Photograph	Photograph

PLACE:

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
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INSURED PERSON DETAILS

POLICY NO:
INSURED PERSON No.
ANNUAL PREMIUM
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 company).

1. Name of the Insured Person :
2. Address :

PIN CODE

State / U.Territory

3. Sex (Strike out whichever is not not applicable) : Male / Female
4. Relationship with the proposer :
5. Date of Birth and Age :
6. (a) Average Monthly Income : Rs.
   (b) Income Tax PAN No. :
7. Profession / Occupation / Trade or Business (Please describe fully With nature of duties) :
8. Name and address of the Medical Practitioner, his qualifications & Telephone No. if any. :

Pincode

Tel. No.

9. Medical Practitioner's Regn. No. :

10. Are you at present or any other time in the past covered Under any other Insurance Type (PA, Cancer Insurance, Hospitalisation Insurance Or other Medical Insurance), If so, Give particulars of :-

(A) Insurer Policy No. Period of cover

(B) If current insurer is United India:

Please specify;

(i) Policy Type Policy No. Office Expiry Date

(ii) Date of first coverage with United India which has since been renewed continuously without break or within grace period

w.e.f _____ under Policy No._____

and Endorsement No._____

(C) Claim amounts received / receivable in preceding two years

Amount (Rs.) Illness Policy Period Insurer 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
(f) 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.,
(i) 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

S.N.	Nature of illness / disease injury and treatment received	Date first treated	Name of attending medical practitioner, surgeon with his address and Telephone Number	Whether fully cured
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 expressed in the Policy.

Signature ---------- Date ---------- / ---------- / ----------

Place: ----------

NAME OF THE PROPOSER / INSURED PERSON ----------
(IN BLOCK LETTERS)

N.B: This should necessarily be signed by insured person. In case of minor, guardian or proposer may sign.

FOR OFFICE USE

Basic Premium for Scheme … Rs. . . . . .

Premium for Additional covers opted Rs. ……

Staff Discount … Rs. . . . . .

TO BE COMPLETED BY PROPOSER IN CASE OF ADVERSE HISOTRY
IN THE PROPOSAL FORM IN RESPECT OF APPLICABLE ILLNESS:

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?
2. 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

Signature of Proposer/Insured person

PLACE :
DATE:

TO BE COMPLETED BY CONSULTING PHYSICIAN / SURGEON
(in case of adverse Medical History)

1. Name of the Insured:
2. HISTORY
   a) Present complaints and investigation if any
   b) Any past history of disease, operation,
      accidents investigations with date, major medical complaints or hospitalisation
   c) Details of present and past medication with duration
   d) Is he cured of disease, if any? When, was your treatment, if any, given, stopped?
3. General Examination
4. Systematic Examination
5. Do you consider the risk acceptable

Signature of proposer

Signature of consulting physician

Name of consulting Physician:
Qualifications:
Address:

Place:
Date:

Telephone Number:

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

DO YOU CONSIDER THE RISK ACCEPTABLE?

COMPETENT AUTHORITY