

**NEW INDIA CRITI PROTECT POLICY
PROPOSAL FORM
URN: (NIA/Health/23-24/CP)**

GUIDELINES FOR COMPLETION OF THE FORM

1. Please answer all questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.
2. Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form. If any additional fact is material, please disclose it.
3. The Policy shall become void, in the event of any untrue or incorrect statement, misrepresentation, non-description or on non-disclosure in any material particular in the proposal form / personal statement, declaration and connected documents, or any material information having been withheld by the proposer or any one acting on his behalf.
4. Kindly contact the Company's Nodal Office or Agent or Intermediary for any doubts or clarifications on the proposal form.
5. The cover is available for Indian citizens and Indian residents only. Persons of Indian origin but resident of other countries or non-resident Indians (NRI) or OCI are not eligible to take this Policy.
6. Please note that this is a Single Member Policy.

NOTE: The liability of the Company does not commence until this proposal has been accepted and premium is received in full.

Intermediary Name: _____ **Intermediary Code:** _____

Part I - Proposer Details

| | | | |
|-----------------------------------|--|------------------------------|--|
| Name of the Proposer | | Date of Birth | |
| Gender | M/F/T | Mobile Number | |
| Email Id: | | GST No(If applicable) | |
| Nature of I-Card | PAN Card/Voter Id/Passport/Any other | Id Card Number | |
| Address for Correspondence | State: _____ City: _____ Pin code: _____ | | |

Part II - Insured details

(To be filled separately for each and every insureds) – All details are mandatory

| | |
|-----------------------------------|---|
| Name | Mr Mrs. Miss |
| | Surname First Name Middle Name |
| Relation with the Proposer | Self/Spouse/Children/Parent |

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| | |
|--|-------------------------------------|
| Father's /Husband Name | |
| Nationality | Indian/Others |
| Current Country & city of residence with address. | City: State: Pin Code: |
| Contact Number | (Landline)(M) |
| Nature of Id card and No | Type of Id-card: Id Card Number: |
| Email Id | |
| Date of Birth (Age limit – 18 to 65 years) | Age :Yrs |
| Gender | M/F/T |
| Marital Status | Single/Married/Others |
| Permanent Account No (PAN No.) | |
| GST No (If applicable) | |
| Current Occupation | |
| Education /Qualification | |
| Employer/ Business Name | |
| Designation | |

Part III: Policy & Plan Details:

| | |
|---|---------------------------|
| Plan Option (9 CI/ 18 CI / 25 CI / 41 CI) (Refer to the Annexure for CI Options) | Please specify the option |
| Are you an Earning Member (Yes/No) | |
| If Yes, Is it Gainful Employment* or Non-Gainful Employment, Please specify | |
| What is your Annual Income (INR) | |
| Sum Insured (INR) | |
| Options Available are 5 L to 50 L (in multiples of 5 L) | |
| Tenure of the Policy (1 Yr or 2 Yr or 3 Yr) | |
| Policy Period | |

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Note:

- a) *Gainful Employment refers to an employment situation where the employee receives steady work, payment from the employer. This means that income from property rent, shares, investment, interest income etc.. shall not be taken into account under Gainful Employment.
- b) For any Sum Assured in excess of INR 25,00,000 Income proof is required. Documents to be submitted for Income Proof:
- ITRS with computation of income for the Latest 2 financial years or,
 - Form 16 of latest financial year or,
 - Last three months pay slips along with bank statement showing salary credits or,
 - Audited P&L account and Balance sheet for the latest two financial years with the share-holding of the applicant

Part IV: Medical Information

- A. Have you suffered / are suffering from any disease / illness or currently taking any medication / consultation from any Doctor for the conditions or diseases or illnesses below? **Yes** **No.....**
- i. Diabetes Mellitus or Impaired glucose tolerance
 - ii. Hypertension
 - iii. Coronary Artery Disease (Angioplasty/Coronary bypass/Heart attack)
 - iv. Congestive Heart Failure/ Conduction Abnormalities of Cardiac System/ Pacemaker implantation / Congenital Heart Disease / Other Heart ailments
 - v. Cerebrovascular Accident (Stroke)
 - vi. Malignancy or Cancer (Leukemia, Sarcoma, etc) Pre malignancy tendencies.
 - vii. Auto Immune Diseases (Rheumatoid Arthritis, SLE, Ankylosing spondylitis etc.)
 - viii. Renal Transplant/ Congenital disorders of Renal System, Renal failure /Chronic renal disorder/ ESRD (End stage renal disorder), Proteinuria
 - ix. Cirrhosis (Alcoholic/Nonalcoholic)
 - x. Multiple Sclerosis
 - xi. Epilepsy
 - xii. Obstructive lung disease, restrictive lung disease, impairment of lung function
 - xiii. Hepatitis
 - xiv. Genetic Disorders
 - xv. Paralysis
 - xvi. Inflammatory bowel disease (Crohn's disease Ulcerative Colitis)
 - xvii. Obese/ Dyslipidemic
 - xviii. Paraplegic/Hemiplegic/Quadriplegic individuals
 - xix. Persons with disability

If 'Yes' or You are suffering from 'Any Other' Conditions or diseases or illnesses, indicate in the table below.

| S. No | Name of Disease Suffering from | Name of the medicines | When First treated | Name of attending medical practitioner with address and telephone no. | If fully cured? Answer Yes / No |
|-------|--------------------------------|-----------------------|--------------------|---|---------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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B. Information for Critical Illness Cover (Medical Questionnaire) – Please write Yes/No

| | | |
|-------------------------------------|---|--------|
| 1 | Are you now in good health & entirely free from any mental / physical impairments or deformities? | Yes/No |
| 2 | Have you ever suffered from or do you suffer from Arthritis, Back Disorder, Diseases of the circulatory system E.g. Heart Disease, Chest pain, High blood pressure, Stroke, Diseases of Arteries / Veins? | Yes/No |
| 3 | Have you ever suffered from or do you suffer from Diabetes Mellitus, Cancer or Tumor of any kind, or any diseases of Blood Glands, Digestive System, Liver, Spleen, Ears Eyes, or Skin? | Yes/No |
| 4 | Have you ever suffered from or do you suffer from diseases of the Respiratory system (Lung Diseases) e g, Tuberculosis, Emphysema, Pneumonia? | Yes/No |
| 5 | Have you ever suffered from or do you suffer from Asthma? | Yes/No |
| 6 | Do you have / had any complaints of difficulty in Breathing, Blood in Sputum or Persistent Respiratory Infections? | Yes/No |
| 7 | Have you ever suffered from or do you suffer from any disease of Genitourinary System / Kidneys? | Yes/No |
| 8 | Have you ever been tested positive for HIV/AIDS or Hepatitis B or C, or have you been tested / treated for other sexually transmitted disease or are you awaiting the result of such test? | Yes/No |
| 9 | Have you ever suffered from or do you suffer from Diseases of the Nervous system or Mental Disorders e.g. Stroke, Epilepsy, Fits / Fainting attacks, Frequent Headache, Paralysis, Multiple Sclerosis, and Psychiatric Disorders? | Yes/No |
| 10 | Do you have any physical disability which is affecting your day-to-day activities? | Yes/No |
| 11 | Have you ever taken Narcotics / other habit forming Drugs or being treated for the same? | Yes/No |
| 12 | Have you been treated for Alcoholism related Diseases? | Yes/No |
| 13 | Whether Occupation requires significant manual labour / hazardous activities / handling hazardous material / explosives or working at height / with high voltage or heavy machinery or are you an unskilled labourer? | Yes/No |
| 14 | Has any of 2 or more family member (Parents and Siblings) ever been diagnosed with diabetes, Hypertension, Kidney Failure, Cancer, Heart Attack or any Hereditary Disorder before the age of 55? | Yes/No |
| 15 | Are you currently suffering from any illness, impairment or taking any medication or pills or drugs? | Yes/No |
| 16 | During last five years have your undergone or recommended to undergo any hospitalization, operation or any other investigations (excluding checkups for employment/insurance/foreign visit)? | Yes/No |
| 17 | Has any application for insurance on your life been postponed, declined, and accepted with extra premium or on other special terms? | Yes/No |
| 18 | Do you take part in any hobbies/ activities that could be considered dangerous in any way? E.g. aviation (other than as a fare paying passenger), mountaineering, deep sea diving or any form of racing? | Yes/No |
| 19 | Have you suffered from any other Diseases or Ailments not mentioned above? | Yes/No |
| 20 | Do you consume tobacco products such as cigarettes, beedi, cigar, pan, Guthkha or any other form of tobacco consumption? If Yes, Please give details below | Yes/No |
| 21 | Do you consume alcohol such as Beer, Wine, Spirit or any other form of alcohol intake? If Yes, Please give details below | Yes/No |
| (For Female Applicants only) | | |
| 22 | Have you suffered from or suffering from any disease of uterus, breast, cervix, ovaries such as fibroid, cyst, lump etc? | Yes/No |
| 23 | Are you currently pregnant? | Yes/No |
| 24 | Do you have a history of past Abortion, Miscarriage or complications during pregnancy? | Yes/No |

Personal Details / Habits.

• Height (in cm):

Weight (in KG):

| <u>Smoking</u> | | <u>Alcohol</u> | | <u>Gutka / Tobacco</u> | |
|---|--------------------------------|--|---|--|---|
| Less than or equal to 10 cigarettes/day | Greater than 10 cigarettes/day | less than or equal to 18 units/week. 1 unit = 30 ml hard liquor/ 1 glass of wine/ 500 ml beer | Greater than 18 units/week. 1 unit = 30 ml hard liquor/ 1 glass of wine/ 500 ml beer | Less than or equal to 5 packets/day. 1 packet= 5gms | Greater than 5 packets/day. 1 packet= 5gms |
| Yes/No | Yes/No | Yes/No | Yes/No | Yes/No | Yes/No |
| Duration Since (in Yrs) | | Duration Since (in Yrs) | | Duration Since (in Yrs) | |

Family Doctor Details

Name: Dr.

Contact Nos. :

Nominee*

| Nominee* | Name of Nominee | Relationship with Applicant | DOB | Age | % of Sum Insured |
|------------------|------------------------|------------------------------------|------------|------------|-------------------------|
| Nominee 1 | | | | | |
| Nominee 2 | | | | | |

* Nominee for self has to be one of the below mentioned relations. "Father, Mother, Son, Daughter, Spouse & Others "

If Nominee is "Others" please specify: -----

*If the Nominee is minor,

• Name of Appointee:

Relationship with Minor:

Part V: HEALTH & DATA DECLARATION

Important:

- The information that you give to us on this proposal form or in any supplementary Information form or documentation supplied by you or on your behalf will influence our decision to offer insurance and the terms upon which to offer it. Further, any policy we issue will be based on what you have communicated to us. It is therefore important that your answer is complete and accurate in all respect.

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- b. The question in this proposal are indicative rather than exhaustive. You must provide us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your intermediary/Insurance advisor/ Insurance Company.
- c. The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.
- d. The Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect statement, misrepresentation, non- description or non-disclosure of material particulars in the Proposal Form/personal statement, declaration and connected documents, or any material fact* information has been withheld by beneficiary or anyone acting on beneficiary's behalf to obtain insurance.

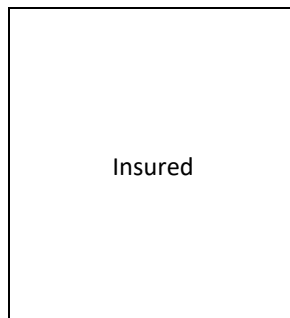
*A material fact will mean and include all important, essential and relevant information, pertaining to the questions made in this proposal form, that are likely to influence company's acceptance or assessment of the proposal.

Proposer Declaration: I declare that the persons proposed for insurance are my family members and I also declare that

- a. 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 authorised to propose on behalf of these other persons.
- b. 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 insurer and that the policy will come into force only after full payment of the premium chargeable.
- c. 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.
- d. I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- e. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority

Signature of Proposer _____ Date: _____/_____/_____ Place: _____

Photographs of Insured Person:



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 an insurance in respect or 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 in the policy, nor shall any person taking out of renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or table of the Insurer.

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

VERNACULAR DECLARATION

Declaration is required in case this proposal is filled by other than Proposer (or) the proposer has signed in vernacular language (or) the proposer is illiterate (It is to be certified by someone other than an agent/employee of the company)

(The content of this form and its particulars have been explained by me in vernacular to the Proposer who has understood and confirmed the same.)

Name of the Translator: _____ Place: _____ Date: _____

Signature of the Translator _____

Name of the Proposer: _____ Place: _____ Date: _____

Signature of the Proposer: _____

FOR OFFICE USE ONLY:

| Name | Premium | Loading | Discount | GST | Premium (Inc GST) |
|------------------------------|---------|---------|----------|-----|-------------------|
| | | | | | |
| Remarks of the underwriter : | | | | | |

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Annexure 1:

| Sr. No. | Critical Illnesses | 9CI | 18CI | 25CI | 41CI |
|---------|--|-----|------|------|------|
| 1 | Cancer of Specified Severity | Yes | Yes | Yes | Yes |
| 2 | Kidney Failure Requiring Regular Dialysis | Yes | Yes | Yes | Yes |
| 3 | End Stage Liver Failure | Yes | Yes | Yes | Yes |
| 4 | Major Organ Transplant/Bone Marrow Transplant | Yes | Yes | Yes | Yes |
| 5 | Open Heart Replacement or Repair of Heart Valves | Yes | Yes | Yes | Yes |
| 6 | Open Chest CABG | Yes | Yes | Yes | Yes |
| 7 | Stroke resulting in Permanent Symptoms | Yes | Yes | Yes | Yes |
| 8 | Permanent Paralysis of Limbs | Yes | Yes | Yes | Yes |
| 9 | Myocardial Infarction (First Heart Attack of Specified Severity) | Yes | Yes | Yes | Yes |
| 10 | Multiple Sclerosis with Persisting Symptoms | No | Yes | Yes | Yes |
| 11 | Coma of Specified Severity | No | Yes | Yes | Yes |
| 12 | Parkinson's Disease | No | Yes | Yes | Yes |
| 13 | Benign Brain Tumour | No | Yes | Yes | Yes |
| 14 | Alzheimer's Disease | No | Yes | Yes | Yes |
| 15 | Aorta Graft Surgery | No | Yes | Yes | Yes |
| 16 | Deafness | No | Yes | Yes | Yes |
| 17 | Loss of speech | No | Yes | Yes | Yes |
| 18 | Third Degree Burns | No | Yes | Yes | Yes |
| 19 | Motor Neurone Disease with Permanent Symptoms | No | No | Yes | Yes |
| 20 | Primary(Idiopathic)Pulmonary Hypertension | No | No | Yes | Yes |
| 21 | Loss of Limb | No | No | Yes | Yes |
| 22 | Muscular Dystrophy | No | No | Yes | Yes |
| 23 | Blindness | No | No | Yes | Yes |
| 24 | Major Head Trauma | No | No | Yes | Yes |
| 25 | End Stage Lung Failure | No | No | Yes | Yes |
| 26 | Systemic Lupus Erythematosus with Lupus Nephritis; | No | No | No | Yes |
| 27 | Pneumonectomy | No | No | No | Yes |
| 28 | Medullary Cystic Disease | No | No | No | Yes |
| 29 | Cardiomyopathy | No | No | No | Yes |
| 30 | Encephalitis | No | No | No | Yes |
| 31 | Progresive Supranuclear Palsy | No | No | No | Yes |
| 32 | Multiple System Atrophy | No | No | No | Yes |
| 33 | Pulmonary Artery Graft Surgery | No | No | No | Yes |
| 34 | Other Serious Coronary Artery Disease | No | No | No | Yes |
| 35 | Apallic Syndrome | No | No | No | Yes |
| 36 | Fulminant Hepatitis | No | No | No | Yes |
| 37 | Creutzfeldt-Jakob Disease | No | No | No | Yes |
| 38 | Aplastic Anaemia | No | No | No | Yes |
| 39 | Severe Ulcerative Colitis | No | No | No | Yes |
| 40 | Progressive Scleroderma | No | No | No | Yes |
| 41 | Bacterial Meningitis | No | No | No | Yes |