navi insurance

Navi Health Super Top Up

PROPOSAL FORM

Proposal Form Number: **URN – NAVIGICCST0319V0**

GUIDELINES OF FILLING THIS PROPOSAL FORM
1) Please complete all sections in capitals and tick the boxes wherever applicable. Please furnish all information that is sought and is having a bearing on the risk.
2) Failure to disclose facts material to the assessment of the risk or providing misleading Information may render the contract void.
3) We shall process the proposal within a reasonable period but not exceeding 15 days from the date of receipt of proposal or any other requirement called by us.
4) Where a proposal deposit is refundable under any circumstances, we shall refund the same within 15 days from the date of underwriting decision on the proposal.
5) This Proposal Form shall be the basis of contract for Policy issuance and shall be signed by the Proposer.
6) We are under no obligation to accept any proposal for insurance. Our liability will commence only when this Proposal is accepted by Us (subject to the policy terms and conditions) and the premium is received and realised.

1. PROPOSER DETAILS

Proposer Name : ☐ Mr. ☐ Mrs. ☐ Ms. ______

Date of Birth : D D M M Y Y   Marital Status : ☐ Married ☐ Unmarried

Gender : ☐ Male ☐ Female ☐ Transgender   E-mail Id : ______

Occupation : ☐ Student ☐ Self Employed ☐ Salaried ☐ House Wife ☐ Retired
☐ Others (please specify) : ______

Aadhar Number* : ______ (* Update either PAN Number or Aadhar Number

PAN Number* : ______ (Mandatory for premium of ₹ 50,000 and above)

Annual Income (₹) : ☐ Up to 5 Lac ☐ 6-10 Lac ☐ 11-15 Lac ☐ 16-20 Lac ☐ Above 20 Lac

SEZ Holder : ☐ Yes ☐ No   GSTIN : ______

Address (Note – This address shall be taken for GST Computation) : ______

Landmark : ______   City / Town : ______

District : ______   Pin Code : ______

Telephone No. : ______   Mobile No. : ______

☐ I hereby consent that the Policy Documents shall be sent to me by e-mail only on my registered e-mail Id. I understand that this authorisation can be revoked by me at the time of renewal by contacting your branch office personally or customer care by writing a mail/ calling your toll-free number.

2. PLAN DETAILS – Please select the required plan and Sum Insured		
Tenure	:	☐ 1 Year ☐ 2 Year ☐ 3 Year
Proposed Policy Period	:	From : D D M M Y Y To : D D M M Y Y
Type	:	☐ Non-Floater ☐ Family Floater A * ☐ Family Floater B**

* Floater A = 2 Adults + Dependent Children (any number up to the age of 30 years)

** Floater B = Parents + Parent in Laws (Proposer can select this option for his/her Parents &/or Parent in laws)

3. DEDUCTIBLE / SUM INSURED DETAILS – Please select the required option	
DEDUCTIBLE	**SUM INSURED**
☐ 2 Lakh	☐ 3 Lakh ☐ 5 Lakh ☐ 8 Lakh ☐ 10 Lakh
☐ 3 Lakh	☐ 3 Lakh ☐ 5 Lakh ☐ 7 Lakh ☐ 10 Lakh ☐ 12 Lakh
☐ 4 Lakh	☐ 3 Lakh ☐ 5 Lakh ☐ 6 Lakh ☐ 11 Lakh
☐ 5 Lakh	☐ 5 Lakh ☐ 7 Lakh ☐ 10 Lakh ☐ 15 Lakh ☐ 20 Lakh
☐ 10 Lakh	☐ 5 Lakh ☐ 10 Lakh ☐ 15 Lakh ☐ 20 Lakh ☐ 50 Lakh
☐ 20 Lakh	☐ 5 Lakh ☐ 10 Lakh ☐ 20 Lakh ☐ 30 Lakh ☐ 50 Lakh ☐ 100 Lakh

4. OPTIONAL COVERAGES – Please select the required option	
☐ Daily Cash Allowance	☐ Waiver of Mandatory Co Payment
☐ Reduction of waiting period for Named Illness	☐ Reduction of waiting period for Pre-Existing Disease
☐ Extension in Pre-Hospitalisation Period	☐ Extension in Post Hospitalisation Period
☐ Room Rent Sublimit	

5. PROPOSED INSURED DETAILS

Sr. No.	Name	Gender	Date of Birth (DD/MM/YYYY)	Relationship with Proposer	Height (Cm)	Weight (Kg)	Occupation	Sum Insured (Only for Non-Floater)
1								
2								
3								
4								
5								

6. NOMINEE DETAILS

In the event of the death of the Policyholder, any payment due under the Policy shall become payable to the Nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. Nominee for persons proposed to be insured shall be the Proposer himself/herself.

Nominee Name	Date of Birth	Relationship with Proposer

If Nominee is minor, please give the name and address of the appointee and relationship with the minor

Appointee Name	Date of Birth	Relationship with Minor

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7. MEDICAL AND HEALTH INFORMATION						
Please answer below mentioned questions		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1.	Has any of person to be insured taken any consultation for or been treated for any pre-existing conditions or had any of the following?					
a)	Any Surgery or Surgical Procedures or any hospitalisation for more than 5 days	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b)	Medication (including oral/ inhalation/ injection/ Topical) for more than 14 days	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c)	Adverse findings to any diagnostic test or investigation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d)	Any persistent symptoms in the past 6 months other than common cold, flu, infections, minor injury or other minor ailments	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e)	Any Cancer, Chronic Kidney Disease, Psychiatric, Neurological (Brain/Spine) or related Disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.	Is any of the female insured pregnant? If yes, please mention the expected date of delivery	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY
3.	Does any of the proposed members have diabetes or pre-diabetes or has he/she ever had high blood sugar?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If Yes, then please tick the relevant option(s) below:					
	How does the applicant manage his/her diabetes / pre-diabetes / high blood sugar?					
	A. Insulin	☐	☐	☐	☐	☐
	B. Oral Diabetic Medication	☐	☐	☐	☐	☐
	C. Homoeopathic or other AYUSH treatment	☐	☐	☐	☐	☐
	D. No Medicine	☐	☐	☐	☐	☐
	How long ago was the applicant first diagnosed with diagnosed with diabetes/ pre-diabetes/ high blood sugar?					
	A. 0-1 Year	☐	☐	☐	☐	☐
	B. 2-5 Years	☐	☐	☐	☐	☐
	C. 6-10 Years	☐	☐	☐	☐	☐
	D. More than 10 Years	☐	☐	☐	☐	☐
4.	Does any of the proposed members have Hypertension / High Blood Pressure?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If Yes, then please tick the relevant option(s) below:					

	How does the applicant manage his/her Hypertension/High Blood Pressure?					
	A. One Medicine					
	B. Two Medicines					
	C. Three or More Medicines					
	D. No Medicine					
	How long ago was the applicant first diagnosed with Hypertension/ High Blood Pressure?					
	A. 0-1 Year	☐	☐	☐	☐	☐
	B. 2-5 Years	☐	☐	☐	☐	☐
	C. 6-10 Years	☐	☐	☐	☐	☐
	D. More than 10 Years	☐	☐	☐	☐	☐
5.	Do you consume tobacco in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If Yes, please specify the details as per below:					
	Type – Cigarette/Beedi/Cigar /Gutkha/Others					
	Quantity per day					
	Consuming for past (Mention no. of years)					
	If you have stopped smoking – Since when	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY
6.	Do you consume alcohol in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If Yes, please specify the details as per below:					
	Type – Beer/Hard liquor/Wine/Others					
	Quantity per week					
	Consuming for past (Mention no. of years)					
	If you have stopped consuming alcohol – Since when	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY
7.	Have you ever had any treatment for depression, anxiety, phobias, stress, mood disorder, eating disorders, sleep disorders or received a diagnosis of any other mental health condition?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

8.	Have you ever had any investigation or consulted any medical practitioner or taking any medications or counselling or Therapy for any signs & symptoms related to Schizophrenia, Bipolar Disorder Delusional disorders, Psychosis, Mental and behavioural disorders due to psychoactive substance, Mental retardation?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9.	Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

8. ADDITIONAL INFORMATION

If any of the proposed insured person is suffering from/suffered in the past/taking treatment for any illness/disease or injury and the same is declared in above Section -7 – (1-4), then please provide further details

Sr. No.	Insured Name	Name of Illness/ Surgery	Date of first diagnosis	Medication Details
1			MM/YYYY	
2			MM/YYYY	
3			MM/YYYY	
4			MM/YYYY	
5			MM/YYYY	

9. CURRENT/PREVIOUS INSURANCE POLICY DETAILS

Are You insured under any Health Insurance Policy? If yes, Please provide the below details.

Insured Name	Policy Number	Insurer Name	Policy Period		Sum Insured	Claim Lodged (if any)	Cumulative Bonus
			From	To			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			

Are you applying for portability? ☐ Yes ☐ No
(If Yes, portability form to be completed and attached)

Do you have any other Insurance Policy from Us ? ☐ Yes ☐ No

If Yes, please mention the Policy Number to avail discount in premium. ____________________

10. PREMIUM PAYMENT AND BANK DETAILS

For Cheque/DD/PO (Payable in favour of Navi General Insurance Limited)

Payment Option: Cheque ☐ Demand Draft ☐ Fund Transfe ☐ Pay Order ☐
Debit Card ☐ Credit Card ☐

Premium Amount: ₹ ________ Amount in Words: ________

Payment Frequency: Quarterly ☐ Half Yearly ☐ Annual ☐

As per the Regulatory requirements, we can affect payment of the refund (if any) and or claims only through Electronic Clearing System (ECS) / National Electronic Funds Transfer (NEFT) / Real Time Gross Settlement (RTGS) / Interbank Mobile Payment Service (IMPS).
For this purpose, please submit the following details of the Proposer's bank account.

Account Holder Name : ________

Instrument Number : ________ Instrument Date : ________

Instrument Amount : ________ Bank Name : ________

Credit/Debit Card No. : ________ Expiry Date : ________

Account No. : ________ IFSC/MICR Code : ________

UPI ID : ________

Type of Account : Saving Bank's Account ☐ Current Account ☐
Others (Please Specify) ☐ ________

Note – If the Premium cheque is not paid from the above-mentioned account then a cancelled cheque leaf of the above-mentioned account is to be attached. *Mandatory if annualized premium is more than ₹.25,000.*

11. ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER

(Email Id is mandatory)
Do you have an EIA : ☐ Yes ☐ No If No, do you wish to apply for EIA : ☐ Yes ☐ No
If Yes, please quote the EIA number : <<____________________________>>
If applied, please mention your preferred Insurance Repository : <<____________________________>>
Email Id (Registered with Insurance Repository) : <<____________________________>>
Your Policy will be credited in your EIA account and your address details as mentioned in the EIA shall override the address provided in this proposal for Insurance. We request you to inform the Repository of any changes in the details immediately.

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12. DECLARATION

1) 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.
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 insurer and that the policy will come into force only after full payment of the premium chargeable.
3) 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.
4) 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.
5) 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."

Date: ______________ Place: ____________ Signature of Proposer ________________________

13. OTHER DECLARATIONS

☐	Any GST liability and payment for the same is dependent on the details (viz GSTIN, address, zero-rating entitlement etc) provided by me. Navi General Insurance Limited will rely on such information for the purpose of compliance with applicable GST regulations and shall not be under obligation to evaluate authenticity/accuracy of the same. Further, in case any GST liability (in terms of tax, interest, penalty and associated litigation cost) arises on Navi General Insurance Limited on account of any incorrect/ incomplete/ non-compliance on behalf of me. I will be immediately liable to pay the same on notification by Navi General Insurance Limited. The said liability shall vest irrespective of the completion of the insurance period covered within the policy contract.
☐	I hereby consent to and authorize Navi General Insurance Limited to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of the Company from time to time.
☐	I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act, 2002. I understand that the Company has the right to call for documents to establish sources of funds. The insurance company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

14. VERNACULAR DECLARATION

I hereby declare that, I have fully explained the contents of the Proposal Form and terms and conditions of the Policy to the Proposer in the language understood to him/her.

Signature/Thumb Impression of the Proposer: ________________________

Name of Witness: ________________________ Signature of Witness: ________________

Date: ________________________ Place: ________________

15. INTERMEDIARY DECLARATION

I, ______________________________ (Full Name), in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

License No./ID (Advisor / Corporate Agent / Broker / Relationship Officer : ______________________

Date: ______________ Place: ______________ Signature of Agent: ______________

Prohibition of Rebates: Section 41 of the Insurance Act, 1938 (and amendments thereof)

1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 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.
2) Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to ten lakh rupees.

INTERMEDIARY DETAILS (FOR OFFICE USE ONLY)

Branch Office	:	Intermediary Code	:
Branch Code	:	Intermediary Name	:
Business Sector	: Urban/Rural/Social	Intermediary contact Number	:

ACKNOWLEDGE SLIP

Proposal form received from: Mr./Mrs./Ms ______________________

Address: ______________ Premium amount: ₹ ______________ To be debited from

Account of Mr./Ms ______________ Account Number: ______________ Bank Name: ______________

Cheque Number: ______________ Date: ______________ Branch: ______________