Navi Health CritiCare

Proposal Form

Proposal Form Number : **URN : NAVIGICCC0519V0**

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.

I. PROPOSER DETAILS

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

Date of Birth : D D M M Y Y Marital Status : ☐ Married ☐ Single ☐ Others

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

Occupation : ☐ Student ☐ Self Employed ☐ Salaried ☐ House Wife ☐ Retired

☐ Others (please specify) : _____

Aadhar Number : _____

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

Annual Income (in ₹) : ☐ Up to 5 Lacs ☐ 5 -10 Lacs ☐ 10 -15 Lacs ☐ 15 -20 Lacs ☐ Above 20 Lacs

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.

II. PLAN DETAILS – Please select the required plan and Sum Insured

Sum Insured	₹_____(Sum Insured will be based on the *Annual Income**)		
* Salaried Person – Maximum Sum Insured will be 5 times of Gross Annual Income (as appearing in Form 16/ Salary Slip/ IT acknowledgement). * Self – Employed Person – Maximum Sum Insured will be 7 times of Gross Annual Income (as appearing in IT acknowledgement / Audited Profit & Loss Account statement) *Non-Earning Person - 50 % of the Earning Proposer's Sum Insured.			
Proposed Policy Period	From: D D M M Y Y	Policy Tenure	☐ 1 Year ☐ 2 Year ☐ 3 Year
Policy Type	☐ Individual ☐ Family# # In case of Family Policy – Sum Insured ~~will be on Individual~~ basis for each member	**NOTE** – Please note that your Policy period will start from the date of receipt of premium to Us. This is applicable only where medical examination or underwriting is not required. In case a medical examination is to be done or an underwriting approval is required, the Policy shall commence on or after the date of approval by underwriter or the date of receipt of any additional premium, whichever is later.	
Waiting Period	30 days ☐ 60 days ☐ 90 days ☐		

Select Your Plan											
Coverage		Basic	Basic+	Enhanced	Enhanced+	Elite	Elite+	SheCare	SheCare+	Cancer Care	My Navi Health CritiCare **
✓ Default Cover		× Not Covered			☐ Optional Cover						
I. Critical Illness		11	11	25	25	41	41	4	4	1	Make Your Own Plan
Group I - Cancer											
1	Cancer of Specified Severity / Major Stage Cancer	✓	✓	✓	✓	✓	✓	✓	✓	✓	Covered
Group II - Heart Related Illnesses											
2	Myocardial Infarction (First Heart Attack of Specific Severity)	✓	✓	✓	✓	✓	✓	×	×	×	Covered
3	Open Chest CABG	✓	✓	✓	✓	✓	✓	×	×	×	☐
4	Open Heart Replacement or Repair of Heart Valves	✓	✓	✓	✓	✓	✓	×	×	×	☐
5	Pulmonary Artery Graft Surgery	×	×	✓	✓	✓	✓	×	×	×	☐
6	Aorta Graft Surgery	×	×	✓	✓	✓	✓	×	×	×	☐
7	Cardiomyopathy	×	×	×	×	✓	✓	×	×	×	☐
8	Primary (Idiopathic) Pulmonary Hypertension	×	×	×	×	✓	✓	×	×	×	☐
9	Coronary Artery Disease	×	×	×	×	✓	✓	×	×	×	☐
Group III - Nervous System & Related Illness											
10	Stroke Resulting in Permanent Symptoms	✓	✓	✓	✓	✓	✓	×	×	×	Covered
11	Permanent Paralysis of Limbs	✓	✓	✓	✓	✓	✓	✓	✓	×	☐
12	Motor Neurone Disease with Permanent Symptoms	✓	✓	✓	✓	✓	✓	×	×	×	☐
13	Coma of Specific Severity	✓	✓	✓	✓	✓	✓	×	×	×	☐
14	Multiple Sclerosis with Persisting Symptoms	✓	✓	✓	✓	✓	✓	×	×	×	☐
15	Bacterial Meningitis	×	×	✓	✓	✓	✓	×	×	×	☐
16	Benign Brain Tumour	×	×	✓	✓	✓	✓	×	×	×	☐
17	Encephalitis	×	×	✓	✓	✓	✓	×	×	×	☐
18	Major Head Trauma	×	×	✓	✓	✓	✓	✓	✓	×	☐
19	Progressive Supranuclear Palsy	×	×	×	×	✓	✓	×	×	×	☐
20	Primary Parkinson's Disease	×	×	×	×	✓	✓	×	×	×	☐
21	Multiple System Atrophy	×	×	×	×	✓	✓	×	×	×	☐
22	Alzheimer's Disease	×	×	×	×	✓	✓	×	×	×	☐
23	Apallic Syndrome	×	×	×	×	✓	✓	×	×	×	☐
24	Spinal Stroke	×	×	×	×	✓	✓	×	×	×	☐
25	Creutzfeldt-Jakob Disease	×	×	×	×	✓	✓	×	×	×	☐
Group IV - Major Organ Related Illnesses											
26	Kidney Failure Requiring Regular Dialysis	✓	✓	✓	✓	✓	✓	×	×	×	☐
27	Major Organ / Bone Marrow Transplant	✓	✓	✓	✓	✓	✓	×	×	×	☐
28	End Stage Liver Failure	×	×	✓	✓	✓	✓	×	×	×	☐
29	End Stage Lung Disease	×	×	✓	✓	✓	✓	×	×	×	☐
30	Progressive Scleroderma	×	×	✓	✓	✓	✓	×	×	×	☐
31	Aplastic Anaemia	×	×	✓	✓	✓	✓	×	×	×	☐

Navi General Insurance Limited
Registered Office: AMR Tech Park, Ground Floor, No. 23 & 24, Hosur Road, Bommanahalli, Bengaluru-560 068
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CIN: U66000KA2016PLC148551 | IRDAI Registration Number: 155

32	Systemic Lupus Erythematosus			×	×	×	×	✓	✓	×	×	×	☐
33	Good Pasture's Syndrome			×	×	×	×	✓	✓	×	×	×	☐
34	Medullary Cystic Disease			×	×	×	×	✓	✓	×	×	×	☐
Group V - Disability Related Illness													
35	Loss of Limbs			×	×	✓	✓	✓	✓	×	×	×	☐
36	Blindness			×	×	✓	✓	✓	✓	×	×	×	☐
37	Deafness			×	×	✓	✓	✓	✓	×	×	×	☐
38	Loss of Speech			×	×	×	×	✓	✓	×	×	×	☐
Group VI - Other Major Illness													
39	Third Degree Burns			×	×	✓	✓	✓	✓	✓	✓	×	☐
40	Pneumonectomy			×	×	×	×	✓	✓	×	×	×	☐
41	Muscular Dystrophy			×	×	×	×	✓	✓	×	×	×	☐
II. SheSmart (Applicable for Women with age group 18 – 55 years)													
1	Severe Osteoporosis			×	×	×	×	×	×	×	✓	×	☐
2	Maternity Benefit			×	×	×	×	×	×	✓	✓	×	☐
	1		Pregnancy Complication Benefit (DIC, Eclampsia, Hydatidiform mole, Choriocarcinoma)	×	×	×	×	×	×				
		a)	Disseminated Intravascular Coagulation	×	×	×	×	×	×				
		b)	Eclampsia	×	×	×	×	×	×				
		c)	Hydatidiform Mole	×	×	×	×	×	×				
		d)	Choriocarcinoma	×	×	×	×	×	×				
	2		Congenital Anomaly Benefit	×	×	×	×	×	×				
		a)	Down's Syndrome	×	×	×	×	×	×				
		b)	Congenital Heart Disease	×	×	×	×	×	×				
			i) Tetralogy of Fallot	×	×	×	×	×	×				
			ii) Transposition of great arteries	×	×	×	×	×	×				
			iii) Ebstein's anomaly	×	×	×	×	×	×				
		c)	Spina Bifida	×	×	×	×	×	×				
III	Additional Critical Illness												
	a)		Angioplasty	×	✓	×	✓	×	✓	×	✓	×	☐
	b)		Early Stage Cancer		✓		✓		✓		✓	✓	☐
	c)		Intermediary Stage Cancer		×		×		×		×	✓	☐
IV	Second Critical Illness			×	✓	×	✓	×	✓	×	✓	×	☐
V	Personal Accident			×	✓	×	✓	×	✓	×	✓	×	☐
VI	Medical Inflation Bonus			×	✓	×	✓	×	✓	×	✓	×	☐
VII	Child Tuition Benefit			×	✓	×	✓	×	✓	✓	✓	×	☐
VIII	Medical Second Opinion			×	✓	×	✓	×	✓	×	✓	×	☐
IX	Health Check Up			×	✓	×	✓	×	✓	×	✓	×	☐
X	Counselling			×	✓	×	✓	×	✓	×	✓	×	☐
XI	Fixed Premium Guarantee			×	✓	×	✓	×	✓	×	✓	×	☐

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XII	Cancer SEEK	×	×	×	×	×	×	×	×	✓
XIII	Cancer Relapse	×	×	×	×	×	×	×	×	✓
XIV	Adjuvant Therapy	×	×	×	×	×	×	×	×	✓
XV	Cancer Support									
	Expert Opinion	×	×	×	×	×	×	×	×	✓
	Counselling - Psychological Counselling - Genetic Counselling - Lifestyle Counselling	×	×	×	×	×	×	×	×	✓
XVI	CareRestore	×	×	×	×	×	×	×	×	✓

** My Navi Health CritiCare Plan - Insured can make his own plan by selecting the coverage of his choice from the above list. However, in order to make his own plan, he has to opt mandatorily 3 illnesses i.e. Cancer of Specific Severity / Myocardial Infarction (First Heart Attack of Specific Severity) / Stroke Resulting in Permanent Symptoms.

III. PROPOSED INSURED DETAILS

S. No.	Name	Gender	Date of Birth	Relationship with Proposer	Height	Weight	SI Opted	Occupation/ Nature of Job	Annual Gross Income (₹)	Pan Card Number
1	Self	M / F	DD/MM/YYYY		Cms	Kgs				
2	Spouse	M / F	DD/MM/YYYY		Cms	Kgs				
3	Child 1	M / F	DD/MM/YYYY		Cms	Kgs				
4	Child 2	M / F	DD/MM/YYYY		Cms	Kgs				
5	Sibling	M / F	DD/MM/YYYY		Cms	Kgs				
6	Parent / Parent in Law	M / F	DD/MM/YYYY		Cms	Kgs				
7	Parent / Parent in Law	M / F	DD/MM/YYYY		Cms	Kgs				

IV. 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	Address of the Nominee

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	Address of the Appointee

V. MEDICAL AND HEALTH INFORMATION

Please answer below mentioned questions		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7
1.	Have you ever had, or been told that you have, or are you currently under consultation or investigation for: (i) cancer (ii) carcinoma in situ (iii) pre-malignant changes (iv) tumor (v) lump or polyp	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.	In the past 2 years, have you had abnormal results or results outside the normal range in a pap smear, mammogram, breast	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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	ultrasound, Biopsy, MRI/PET Scan, Bone Scan, Digital Rectal Exam, prostate examination or tumour marker blood test?							
3.	In the past 6 months, have you experienced any persistent symptoms, unexplained weight loss of 5kg or more; blood in urine , persistent coughing, bleeding from the bowels or in stools, diarrhoea or constipation for 30 days or month	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.	Any Chronic Disease, High Blood Pressure, High Blood Sugar, Psychiatric, Neurological (Brain/Spine), Heart disease, Stroke or related Disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5.	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	☒ Yes DD/MM/YY	☐ Yes DD/MM/YY
6.	Do you consume tobacco in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If Yes, please specify the details -							
7.	Do you consume alcohol in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If Yes, please specify the details (quantity per week / consuming since how many years etc) :							
8.	Has any application of life or health insurance ever been declined, loaded or been subject to any special conditions by an insurance company?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Note - In case of additional members and there is insufficient to provide health information, please attach extra sheet duly signed.)

VI. 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 -V.1-4, then please provide further details

Sr. No.	Insured Name	Name of Illness/ Surgery	Date of first diagnosis	Medication Details	Name & Contact details of Treating Medical Practitioner
1	Self		MM/YYYY		
2	Spouse		MM/YYYY		
3	Child 1		MM/YYYY		
4	Child 2		MM/YYYY		
5	Child 3		MM/YYYY		
6	Sibling		MM/YYYY		
7	Parent		MM/YYYY		
8	Parent		MM/YYYY		
9	Parent in Law		MM/YYYY		
10	Parent in Law		MM/YYYY		

VII. 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. _____

VIII. PREMIUM PAYMENT AND BANK DETAILS

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

Payment Option: Cheque ☐ Demand Draft ☐ Fund Transfer ☐ 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.*

IX. 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.

X. 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 _____

XI. 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 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.

XII. 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: _____

XIII. 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: _____