Bajaj Allianz General Insurance Co. Ltd. G.E. Plaza, Airport Road, Yerawada, Pune - 411 006.

For Agent Use Only:

For Office Use Only:

Scrutiny No.	Receipt No.	Policy No.

For Agent Use Only:

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Emp/LG Code	Loan Account Number	IMD Code	Sub IMD Code	IMD Name	Mobile No.

PERSONAL ACCIDENT POLICY PROPOSAL FORM

Instructions For Filling Up The Form:-

- Please answer all questions in BLOCK letters 1.
- 2.
- The Liability of the Company does not commence until this Proposal has been accepted by the Company and premium has been paid
 This Proposal will be the basis of any subsequent policy that we issue to you. It is therefore essential that you provide all the information in this Proposal FULLY AND 3. ACCURATELY and that you provide us with any and all additional information relevant to risk to be insured or our decision as to acceptance of the risk or the terms

Proposar Details
Proposer Details
1) Full Name: Title First Name First Name
Middle Name Surname Surname
2) Are you an existing Bajaj Allianz Customer: Yes / No If yes, please mention the Policy No: OG
3) Gender: Male Female Other 4) Date of Birth D D M M Y Y Y S 5) PAN No.
6) UID/Unique ID: 7) Bajaj Allianz Employee Code, if Proposer is BAGIC/BALIC Employee
8) Marital Status: Married Single Divorced Widowed 9) No. of Children Sons Daughters
10) Occupation Business Salaried Professional Student House Wife Others
11 a) Permanent / Residential Address 11 b) Correspondence Address: (All the communications will be sent to the below address)
House No. House House No. House
Landmark/ Landmark/
Locality
Area Name Area Name Area Name
City/District Ci
State Pin Code State Pin Code
Tel. Tel.(Res.)
Mobile Tel.(Office)
Email Mobile Number
E-Mail
12) Educational Qualification: Matriculate Under Graduate Graduate Post Graduate Professionally Qualified
13) Family Monthly Income: Up to Rs. 20,000 Rs. 20,001 to Rs. 50,000 Rs. 50,000 Above Rs. 1 lakh
14) In case of any Offer, you would prefer to be contacted by: Phone Email 15)Nationality
16) Details of the persons to be insured
Sr Name DOB (dd/mm Age Gender Occupation Any Existing Monthly Premium
No Name (dd/mm /yy) Age (M/F) Occupation disability / infirmity Monthly Income Premium
47) New Pote its
17) Plan Details
Sr No Name Of Insured Basic SI Wider SI Comprehensive SI Medical Expenses Hospital Confinement (Yes/No) Allowance (Yes/No)

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Jeii				+	
	Nominee 3				
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Declaration					
Decidration					
		n behalf of all persons proposed to be nowledge and that I/We am/are auth			s and/or particulars given by me are true and sons.
		led by me will form the basis of the of force only after full receipt of the pre		ıbject to the Board app	proved underwriting policy of the insurance
I/We further submitted bu	declare that I/we will notify i t before communication of t	n writing any change occurring in the he risk acceptance by the company.	occupation or general	health of the life to be i	nsured/proposer after the proposal has been
☐ I/We declare	and consent to the company	seeking medical information from ar	ny doctor or from a hos	pital who at anytime ha	ns attended on the life to be insured/proposer I/proposer and seeking information from any
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- *** This is required only where, for any reason, the Proposal Form and other connected papers are not filled by the Prospect/Proposer.

 ** Please read declaration wordings carefully before signing the proposal form.