

1800 3002 8282 (toll free) 3989 8282 (local charges apply) www.reliancegeneral.co.in

Proposal Form for Reliance Individual Mediclaim Policy (to be filled in ALL RESPECTS in BLOCK LETTERS)

	Intermediary Details										
	Intermediary Details							\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 .		
Intermediary Name Branch Name								Code Code			
	es Manager Name							Code			
Sale								Code			
	Proposer's Details			F I D C			4 1 0 0				A 6 T
Name of the Proposer			Ms.	F I R S			M, I, D, D	LIE			A 5 1
	dress of the Proposer	Plot No	./Door No	0.	Bui	ilding Name					
Roa	nd/Street/Sector										
Are											
Taluka/Village/District/City								Pin C	1		
Sta								Coun	try		
	idence Number						Mobi	le L			
Em	ail ID					Pan	Number				
	Family Doctor Details										
Nar	me	Dr. F	I R S	ST		MII	DLLE			L	AST
Add	lress for the Doctor	Plot No	./Door No	о. 🗀 🗀	Bu	ilding Name					
Roa	nd/Street/Sector										
Area	a										
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Tele	ephone						Mob	ile L			
Fax							Qual	lification L		1 1	1 1 1 1
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· un	Details of Insured Person	n/(s) (Th	ne person/(s) to be Insure	ed)						
Sr.	Details of Insured Person	n/(s) (Th	Date of	s) to be Insure	Relationship		Is there	any	Nominee		Relationship
	i					Sum Insured		any disease/	Nominee Name		Relationship with Insured
Sr.	i		Date of		Relationship with the		Is there	any disease/			
Sr.	i		Date of		Relationship with the		Is there	any disease/			
Sr.	i		Date of		Relationship with the		Is there	any disease/			
Sr.	i		Date of		Relationship with the		Is there	any disease/			
Sr.	Name	Gender	Date of Birth	Occupation	Relationship with the Proposer	Insured	Is there pre-existing illness/co	any disease/ ndition	Name	v	vith Insured
Sr.	Name	Gender	Date of Birth	Occupation	Relationship with the Proposer	Insured	Is there pre-existing illness/co	any disease/ ndition		v	
Sr. No.	Name Are/were you a regular Smo	Gender L L L L L L L L L L L L L L L L L L	Date of Birth	Occupation L L I Tobacco (ch	Relationship with the Proposer	Insured Gutka, Pan M	Is there pre-existing illness/co	any disease/ ndition	Name — Yes	v	with Insured
Sr. No.	Name Are/were you a regular Smooth of the second of the s	Gender	Date of Birth	Occupation L L I Tobacco (ch	Relationship with the Proposer	Insured Gutka, Pan M	Is there pre-existing illness/co	any disease/ ndition	Name	v	vith Insured
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		order of urinary	tract or kidne	ys, blood dis	order, any men		nditions, any dis		
es, indicate in the	e table given be	elow					Yes	☐ No	
Does any person to be insured receive any treatment/ medication or has he/she in the past received treatment to any medical condition?									
If yes, indicate in the table given below Yes No									
other information	on relevant for t	this insurance.							
Name	e of disease/illr			When first treated	Name of attending medical practitioner/ surgeon with his address and telephone no.		If fully cured?		
					I	T			
					1	1			
tails of Other I	nsurance Poli	су							
tails of any other	Insurance like	Mediclaim, Cand	cer Policy, Cri	tical Illness o	r any other Me	edical Insurance Poli	cy (Please attac	ch a photocopy)	
Name and address of Insurance Company		Sum Insured (Rs.)	Insured (Ps.) From To			Claims Received/ Receivable (Rs.)	Nature	of claim	
		1	l						
	ive Bonus (plea	se attach necess	ary proof form	n the insuranc	e company with	n whom you have the	expiring insuran	ce policy)	
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or DD Amount		/-	Amount in v	vords ()	
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	tails of Other I tails of Other I tails of any other Name tails of previous c ails of Commulat wment Details que or DD Amount me DD No. claration eby declare that the d and agreed that th t is found that any of eby understand and dress etc given by in dred services of Peliar ie and undertake to sal form. Insurance starting from	tails of Other Insurance Politails of January Company ails of Previous claims history (valids of Commulative Bonus (pleasured Totals o	vous system, fits (epilepsy) slipped disc, backaches, indicate in the table given belowes any person to be insured receive any treatments, indicate in the table given belowes, indicate in the table given belower, other information relevant for this insurance. Name a) Name of disease/illn b) Treatment/ medicatin b) Treatment/ medicatin Name and address of Insurance Company Insured (Rs.) ails of previous claims history (where required prails of Commulative Bonus (please attach necession DD Amount Insurance Company Insured (Rs.) company Insured (Rs.)	vous system, fits (epilepsy) slipped disc, backache, any congees, indicate in the table given below as any person to be insured receive any treatment/ medications, indicate in the table given below or other information relevant for this insurance. Name a) Name of disease/illness/injury sub) Treatment/ medication received/ b) Treatment/ medication received/ tails of Other Insurance Policy tails of any other Insurance like Mediclaim, Cancer Policy, Cri Name and address of Sum Insured (Rs.) Name and address of Insured (Rs.) Amage of Sum Insured (Rs.) Period of From dd/mm/yy ails of previous claims history (where required please furnish ails of Commulative Bonus (please attach necessary proof form to the property of the pr	vous system, fits (epilepsy) slipped disc, backache, any congenital/birth des, indicate in the table given below as any person to be insured receive any treatment/ medication or has he/es, indicate in the table given below as any person to be insured receive any treatment/ medication or has he/es, indicate in the table given below as other information relevant for this insurance. Name	wous system, fits (epilepsy) slipped disc, backache, any congenital/birth defects/disease es, indicate in the table given below es any person to be insured receive any treatment/ medication or has he/she in the pase, indicate in the table given below or other information relevant for this insurance. Name a) Name of disease/illness/injury suffering from b) Treatment/ medication received/ receiving treated treated treated treated tails of Other Insurance Policy tails of any other Insurance like Mediclaim, Cancer Policy, Critical Illness or any other Mr. Name and address of Insurance (Rs.) Name and address of Insurance (Rs.) Insurance Company Insured (Rs.) To dd/mm/yy dd/mm/yy ails of previous claims history (where required please furnish details in a separate sheet; ails of Commulative Bonus (please attach necessary proof form the insurance company with the proposal form are tred and agreed that the statements, answers and particulars given by me / us in this proposal form are tred and agreed that the statements, answers and particulars provided hereinabove are the basis on which its found that any of the statements, answers and particulars are incorrect or untrue in any respect, the Co between the proposal form are tred and agreed that the statements, answers and particulars are incorrect or untrue in any respect, the Co between the Reliance General Insurance Co. Ltd. and share my/our companies. Yes et and undertake to convey to Reliance General Insurance Co. Ltd. and share my/our companies. Yes et and undertake to convey to Reliance General Insurance Company Limited any change/alterations casel form.	wous system, fits (epilepsy) slipped disc, backache, any congenital/birth defects/diseases, AIDS or tested poes, indicate in the table given below so any person to be insured receive any treatment/ medication or has he/she in the past received treatment es, indicate in the table given below or other information relevant for this insurance. Name a) Name of disease/fillness/injury suffering from b) Treatment/ medication received/ receiving when first treated practitioner/ sur address and te b) Treatment/ medication received/ receiving when first treated practitioner/ sur address and te load of the provided previous claims history (where required please furnish details in a separate sheet) ails of Commulative Bonus (please attach necessary proof form the insurance company with whom you have the proposal form are true to the best of my / Amount in words (me DD No. Charatton by declare that the statements, answers and particulars given by me / us in this proposal form are true to the best of my / Cheque/DD Date claration claration by declare that the statements, answers and particulars given by me / us in this proposal form are true to the best of my / Sub yourderstand and agree that Reliance General Insurance Co. Ltd. may share my/our contact information like name, companders et cylone by me / us in this proposal form are true to the best of my / Yes DNo. Claration by declare that the statements, answers and particulars given by me / us in this proposal form are true to the best of my / Yes DNo. Cheque/DD Date DA mount in words (The proposal form are true to the best of my / Yes DNo. Cheque/DD date DA mount in my yes proposal form are true to the best of my / Yes DNo. Cheque/DD date DA my yes proposal form are true to the best of my / Yes DNo. Cheque/DD date DA my yes proposal form are true to the best of my / Yes DNo. Cheque/DD date DA my yes proposal form are true t	ails of Company Sum	

- 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 or 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 on the policy, not 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 published prospectuses 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 Rs. 500/-

Registered & Corporate Office Address

Reliance General Insurance Co. Ltd.

Registered Office: Reliance Centre, 19, Walchand Hirachand Marg, Ballard Estate, Mumbai - 400 001

Corporate Office: 570, Naigaum Cross Road, Next to Royal Industrial Estate, Wadala (W), Mumbai - 400 031

