	E COMPLETED BY PROPOSER IN CASE OF ADVERSE HISTORY IN THE PROPOSA etes Questionnaire:	L FORM IN RESPECT OF APPLICABLE ILLNESS
1.	When was Diabetes Mellitus detected?	
2.	Do you take any antidiabetic drugs? If so, give names with dose	
3.	Please give details of Fasting and Postprandial Blood Sugar Readings, ECG findings and other investigation reports. Please also send reports (Latest)	
4.	Do you suffer or have suffered from any complication of diabetes mellitus?	
Нуре	rtension Questionnaire :	
1.	What is your Blood Pressure reading?	
2.	Please state names of antihypertensive drugs with dose.	
3.	Is it Essential/Secondary  Please state whether you have suffered from any complications from hypertension	
5.	Please give findings of all investigation reports available	
_	t Pain or Coronary insufficiency or Myocardial Infarction Questionnaire :	
1.	Did you ever suffer from chest pain or coronary insufficiency or myocardial Infarction?, if so, please give diagnosis and date	
2.	Please state the names and dose of drugs you are taking at present.	
3.	Please state the findings with dates of investigations done like ECG, Stress test, coronary angiography, X-ray, pathology reports, etc. Please send reports with the proposal form.	
4.	Please state the date of hospitalisation and names of hospitals and consultants.	
5.	Please state whether you can do your regular work and whether you have any limitation of activity.	
6.	Are you advised any special treatment? If so, please give information	
Place Date		Signature of the Proposer
то ві	E COMPLETED BY CONSULTING PHYSICIAN/SURGEON	
1. 1	Name of the Proposer	
	Relevant History (If necessary, please attach separate sheet)	
3. [	Details of present and past medication with duration	
4. (	General Examination	
Sigr	nature of Proposer : Signature of Consulting	Physician :
Date	e : Name of Consulting Ph	ysican :
Plac	ce : Qualifications & Addres	s :
I here from a menta is four the instantal	by declare and warrant that the above statements are true and complete. I consent and any hospital/medical practitioner who has at any time attended or may attend concerning all health. I agree that this proposal shall form the basis of the contract should the insurant that the statements, answers or particulars stated in the proposal form and/or other surrance company incur no liability under this policy.  The read the prospectus and am willing to accept the coverage subject to the terms a lance Company therein.	g any disease or illness which affects my physical o ance be effected. If after the insurance is affected i questionnaire are incorrect or untrue in any respec
1.	3.	
2.	4.	
Dated	(Signature of the Pro (This should be signed by the insured. In case of minor, guardian	
For C	Office use only:	
	psal Recd. on DDMMYY	
	essed by Date D D M M Y Y	
	oved by Date D D M M Y Y	
	omer ID	



## STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED Regd. Office: 9/3, Madha Church Road, Mandaveli, Chennai - 600 028.

## MEDI-PREMIER PROPOSAL FORM

	PROPOSAL. NO. :	MP/		I	ssuing Office				
Premium Payment Detai	ils : Cash Cr	neque	DD	Cheque/D	D No.			Date	
Coverage Required : Fro	om D D M M Y Y	To D D	M M Y Y	Advance I	Receipt No.			Date	
Bank Name/Branch									
Mktg. Officer Name				Code N	No				
Agents Name :				Code N	No O				
Corporate Agent's				Code I	No				
The Company will not be BLOCK letters. Please sage of the person must be undergo Medical Examinabove the information to Business Type	submit stamp size photoe written on the reverse nation by our Panel Do be given, please seek	ographs of se of the plactors at the adviced	f each of the noto. Persons e discretion o e and guiden	persons properties above 45 of the Comm	roposed for ins years and of F pany before ac	surance for in Persons with ecceptance of	ssuance adverse this pro	of Identity C	Cards. Name an story may have t
1. PROPOSER DETA		s. Ms							
Name of Proposer	st Name		Middle	Name		Las	t Name		
Permanent Address									
City/Taluk		District			State			Pin Code	
Address for Communication									
City/Taluk		District			State			Pin Code	
STD Code	Phone No.			Fax		C	Cell		
E-mail					IT	Pan No.			
Marital Status of Propos	ser Single		Married		Widow		Wido	wer	Divorce
Educational Qualification	n		Occupation						
Existing SHAICL Custon	mer Y N		If yes, Custon	mer Code I	No :				
2. DETAILS OF PER	SON(S) TO BE COVE	RED INCL	UDING PRO	POSER					
Name of the Person to b	ne 1			2		3			4
Insured									
Relationship with the Proposer									
Date of Birth	D D M M Y Y	Age	D D M M Y	Age	DDM	M Y Y Ag	е	D D M M	Y Y Age
SUM INSURED									
Educational Qualification	n* NM M G	PG PC	NM M	G PG	PC NM N	I G P	G PC	NM M	G PG PC

Downloaded from www.insureatclick.com - Broker: Loyal Insurance Brokers Ltd.

(NM - Non-Matric, M-Matric, G-Graduate, PG - Post Graduate, PC - Professional Course)

				_						
Occupation**										
	** Occupation Business - <b>B</b> , P	: Service - rofession - <b>P</b> , S								
Average Monthly Income	e									
Are you covered under any other Medical Insurance policies or or any other such schem	Y	N	Y	N		Y	N	Y	N	
If yes, details of : Name of the Insurance Company										
Period of Insurance										
Sum Insured										
ATTACH STAMP SIZE PHOTOS FOR ISSUE O ID CARDS	)F Siz	Stamp Size Photo-1		Stamp Size Photo-1		Stam Size Photo		Stamp Size Photo-1		
		Fa	amily Detail	s - of the	Proposer					
Family Member	Age		alth status if		Age	e when died not alive	t l	Cause of c	leath	
Father										
Mother										
Brothers										
Sisters										
Spouse										
Spouse Children										
Children	ollowing informat	ion (Yes/No)				Insured 1	d Insured	I Insured	Insured 4	
Children  3. PLAN DETAILS  Please provide the form  Are you in good hea	Ith and free from	physical and	d mental di	sease or	infirmity or					
Children  3. PLAN DETAILS  Please provide the form	Ith and free from If not, give full de cal insurance refus	physical and etails.	or higher pre	emium cha						
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k. Fis	stula, piles, Hernia, Varicose Veins.		
I. An	y dimness of vision, cataract		
m. His	story of tonsillitis or any other disease or disorder of the Ear, Nose or Throat.		
n. An	y dental problems		
o. Sli	pped disc, other spinal disorder or paralysis of any kind		
p. An	y nervous, mental or psychiatric disease		
q. An	y other illness or disease or accidents suffered by you		
	ive you ever taken narcotics or other habit forming drugs or been treated or vised in connection with your alcohol consumption or taking of drugs.		
S. Ha	ive any of these persons who proposed for insurance :		
1.	Had any life/health/disability/cover declined/modified/postponed		
2.	Had an ECG, X-Ray, blood/diagnotic test performed		
3.	Has any medication been presctibed in the past 12 months		
4.	Been advised or surgery but not yet done		
5.	Receiving payment for disability/illness/injury		
6.	Had a change of weight of >5 Kgs. in the past 12 months		
7.	Been treated as in-patient or out-patient for surgery		
	Had any medical treatment for mental or physical impairment.		

## Nature of illness/diseases injury and treatment received Date first treated surgeon with his address and Telephone Number 1. 2. 3. 4.

Family Physician's Name	
Address	
City/Taluk	District State Pin Code
STD Code	Phone No. Cell Regn. No.

## 4. ASSIGNMENT

In the event of death of the Insured Person, all the benefits that shall become payable under the policy will be paid to the person named as the 'Assignee' by the Insured Person and his/her receipt shall be sufficient discharge to the Company.

SI.	Name of the Person Proposed	Name of the Assignee	Relationship	Signature of the Insured Person
1.				
2.				
3.				
4.				

Section-41 of Insurance Act 1938 (Prohibition of Rebates): 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 of risk relating to lives or property in India any rebate of the whole or part of the commission payable or any rebate on the 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 punishable with fine which may extend to five hundred rupees.