	UNITED INDIA INSURANCE Co. Ltd.. **Registered & Head Office :** **24, Whites Road, Chennai – 600 014**	Issuing office address

MEDICLAIM INSURANCE PROPOSAL FORM

(INDIVIDUAL)

Policy No | | | | | | | | | | | **Dev Officer Code** | | | | | | | | | | |

Annual Premium Rs. | | | | | | | | | | | **Agency Code** | | | | | | | | | | |

IMPORTANT

a) The Company will not be on risk until the proposal and insured persons details have been accepted by the company and communication of the acceptance has been given to the proposer in writing on full payment of premium.

b) If other family members residing with proposer i.e., spouse, eligible dependent children dependent parents required to be covered, separate insured person details forms should completed for each of such family members.

PROPOSER DETAILS

1. NAME OF THE PROPOSER

[Surname] [Name]

2. ADDRESS & TEL NO. 1) Residence :

2) OFFICE :

3. Totalnumber of members to covered [in figures] :
[in words] :

[Separate Insurance Person Details forms are to be enclosed]

4. Period of Insurance From

To [midnight]

Signature of the proposer

S. No	Name of the Insured person	Age	Sex	Relation	C. S. I.	Signature
1						
2						
3						
4						
5						

Photographs of Insured persons:

Photo-graph	Photo-graph	Photo-graph	Photo-graph	Photo-graph

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 a part of commission payable or any rebates of the premium ï shown on the policy nor shall any person taking out or renewing continuing a policy except any rebates as a may bee allowed in accordance with the published prospectus 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 five hundred rupees.

ANNEXURE "A"

TO BE COMPLETED BY PROPOSER IN CASE OF ADVERSE HISTORY IN THE PROPOSAL FORM IN RESPECT OF APPLICABLE ILLNESS

DIABETES QUESTIONNAIRE

1. Date of Diagnosis of Diabetes :
2. Did you suffer from coma or procoma? :
3. Do you take any antidiabetic drugs?
   If so, please give names with dose.
4. Please give details of Fasting and Postprandial Blood Sugar readings, E. C. G. Findings and other Investigation reports with dates. Please also send reports
5. Do you suffer or have suffered from any complications of diabetes or any other disease? :

HYPERTENSION QUESTIONNAIRE

1. What is your Bloodpressure reading?
   Please state with dates? :
2. Please state names of anihypertensive drugs with dose :
3. Are you a smoker? :
4. Is it Essential / Secondary / Malignant Hypertension ? :
5. Please state whether you have suffered from any complications or other disease :
6. Please give finding of all investigation reports :

CHEST 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 investigation 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 complications and other diseases if suffered :
6. Please state whether you can do your regular work and whether you have any Limitation of Activity :
7. Are you advised any special treatment?
   If so, please give information :

Place :

Date : Signature of the proposer

ANNEXURE ñBò

TO BE COMPLETED BY CONSULTING PHYSIAN / SURGEON

[In Case of adverse Medical History]

1. NAME OF INSURED :
2. History
   a) Present complaints and investigations, if any :
   b) Any past history of diseases, operations accidents, investigations with date, major medical complaints or hospitalsation :
   c) Details of present and past medication with duration :
   d) Is he cured of diseases, if any? When was your treatment, if any, given, stopped? :
3. General Examination :
4. Systematic Examination :

Signature of proposer

Date

Place

Signature of Consulting Physician

Name of consulting Physician

Qualification

Address

Telephone Number:

TO BE COMPLETED BY OFFICIAL OF INSURANCE COMPANY

Do you consider the risk acceptable?

Competent Authority

Branch Manager

Divisional Manager

Order No 90/22.01.03 cp 1 + 1x3x50 ï 15000C