UNITED INDIA INSURANCE COMPANY LIMITED

Regd. & Head Office : 24, Whites Road, Chennai – 600 014

PROPOSAL FORM FOR OVERSEAS MEDICLAIM POLICY

(Business & Holiday)

(To be submitted in Original with 2 copies)

(Available to persons in the age group of 6 months to 70 years)

IMPORTANT

PLEASE MAKE SURE YOU READ AND FULLY UNDERSTAND THIS DOCUMENT BEFORE YOU TRAVEL FROM THE REPUBLIC OF INDIA

FAILURE TO FOLLOW THE INSTRUCTION GIVEN COULD RESULT IN REJECTION OF ANY CLAIM THAT MIGHT BE MADE.

THE OVERSEAS MEDICLAIM POLICY PROVIDES INDEMNITY FOR EXPENSES NECESSARILY INCURRED FOR IMMEDIATE TREATMENT OF ILLNESS, DISEASES CONTRACTED OR INJUSRY FIRST SUSTAINED (DURING THE PERIOD OF INSURANCE OF OVERSEAS TRAVEL SUBJECT TO POLICY TERMS AND CONDITIONS) AND IN ADDITION ALSO PERSONAL ACCIDENT, TOTAL LOSS OF CHEKCED BAGGAGE, DELAY OF CHECKED BAGGAGE, LOSS OF PASSPORT AND PERSONAL LIABILITY COVERS. (DURING THE PERIOD OF INSURANCE OF OVERSEAS TRAVEL SUBJECT TO POLICY TERMS AND CONDITIONS)

IN THE ABSENCE OF MEDICAL REPORTS AS SPECIFIED IN ITEM IIB SUM INSURED WILL STAND REDUCED TO AN EQUIVALENT AMOUNT OF US$ 10,000 IN RESPECT OF MEDICAL EXPENSES INCURRED THROUGH ILLNESS OR DISEASE ONLY. SUBJECT TO EXCLUSION OF PRE-EXISTING DISEASE.

THE ATTENTION OF THE PROPOSER IS DRAWN TO ITEM II (MEDICAL HISTORY) OF THE PROPOSAL FORM ESPECIALLY IN RELATION TO PREVIOUS TREATMENT FOR ILLNESS OR DISEASE SUCH AS RENAL DISORDERS OR DISEASES, CEREBRAL OR VASCULAR STROKES, HEART AILMENT OF ANY KIND, MALIGNANCY, TUBERCULOSIS, ENCEPHALITIS, NEUROLOGICAL DISORDERS, GALL BLADDER DISORDER, ARTHRITIS REQUIRING SURGERY AND IF ANY TRETMENT HAS BEEN RECEIVED FOR ANY OF THE ABOVE DISORDERS AT ANY TIME IN THE PAST SUCH TREATMENT MUST BE DISCLOSED TO THE POLICY ISSUING OFFICE.

NEITHER THE INSURERS NOR CLAIMS SETTLING AGENT SHALL BE RESPONSIBLE FOR THE AVAILABILITY, QUALITY OR RESULTS OF ANY MEDICAL TREATMENT OR THE FAILURE OF THE INSURED TO OBTAIN MEDICAL TREATMENT.
THE PROPOSAL FORM SHOULD BE COMPLETED TO THE BEST OF YOUR KNOWLEDGE AND BELIEF AND ALL MATERIAL FACTS SHOULD BE DISCLOSED. FAILURE TO DO SO MAY NULLIFY COVER UNDER THE POLICY ISSUED.

NOTE : Plan A-1 & A-2 (Worldwide travel excluding USA/Canada)
Plan B-1 & B-2 (Worldwide travel including USA/Canada)
Plan E-1 & E-2 (Corporate Frequent Travel to all destinations including USA/Canada)

IF

a) The proposer is travelling to USA and / or Canada and is above 40 years,

OR

b) The proposer is travelling to any other country and is above 60 years,

OR

c) Answer to questions in II (A) reveal that the proposer had suffered any time in the past or is suffering from any disease/illness,

the Proposal Form should be accompanied with I) ECG printout with report and 2) Fasting blood sugar and Urine Sugar/Urine Strip test Report or any other medical report required by the company etc., alongwith the attached questionnaire II (B) to be completed and signed by the doctor with minimum M.D. qualification conducting the test. In the absence of such medical tests and report due to a shortage of time before travel, cover may still be granted subject to a satisfactory proposal form but the sum insured under policy, in respect of expenses incurred for the treatment of illness or disease shall be restricted to US $ 10,000 only which shall not cover the cost of Medical treatment for pre-existing disease. In case of accident however the full sum insured benefit would be available.

I.GENERAL INFORMATION

1. NAME OF THE PROPOSER (IN BLOCK LETTERS) AS STATED IN THE PASSPORT : MR./MRS./MISS./MASTER

2. HOME ADDRESS & TELEPHONE NO. :

3. PROPOSERõS ACTUAL OCCUPATION (Specify) :

4. OFFICE ADDRESS :

5. TELEPHONE NO. :
6. AGE (IN COMPLETED YEARS) : _____DATE OF BIRTH_____

7. PASSPORT NO. : _____
DATE OF EXPIRY & NAME OF PASSPORT ISSUING AUTHORITY

8. PLAN OPTED FOR : A-1 A-2 B-1 B-2 E-1 E-2
(Please tick relevant plan) ☐ ☐ ☐ ☐ ☐ ☐

9. PURPOSE OF VISIT :
(BUSINESS/HOLIDAY TRAVEL)

10. PROPOSED DATE OF DEPARTURE FROM REPUBLIC OF INDIA i.e. FIRST DAY OF INSURANCE : DAY MONTH YEAR

11. INSURANCE REQUIRED FOR :
(Number of days)

N.B.: 1. There will be no refund of premium in case you return to india before expiry of policy
2. In case of any extension of stay abroad, requiring extension of policy period, approval of issuing office has to be obtained and appropriate premium paid before expiry of policy. Request for extension should be supported with a declaration of good health.

12. COUNTRIES TO BE VISITED
(State appropriate number of days at each place)

II MEDICAL HISTORY

(A) TO BE COMPLETED BY THE PROPOSER

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH ôYESô OR ôNOô (A DASH IS NOT SUFFICIENT) AND GIVE FULL DETAILS

1. Are u in good health and free from physical and mental disease or infirmity _____
2. Have you ever suffered from any illness or disease upto the date of making this proposal _____
3. Do you have any physical defect or deformity _____
4. Have you ever been admitted to any hospital/nursing home/clinic for treatment or observation _____
5. Have you suffered from any illness/disease or had an accident in the 12 months Preceding the first day of insurance. _____
6. If the answer is óyesô to any of the foregoing questions please give full details as under :

Nature of illness/disease/injury & treatment received	Date on which first treatment taken	First treatment completed/ is continuing	Name of attending medical practitioner / surgeon with his address & Tel Nos

7. a) Have you any intention of engaging in professional sports?
b) If so, please give details _____
_____

8. Please give details of any knowledge of any positive existence of any ailment , sickness or injury which may require medical attention whilst on tour abroad.

I HEREBY DECLARE THAT

1. I will not be travelling against the advice of a physician.
2. I am not on the waiting list of any medical treatment
3. I will not be travelling for the purpose of obtaining medical treatment

4. I have not received a terminal prognosis for a medical condition before this day

Assignment:

I, ... do hereby assign the monies payable under the policy in the event of my death to my ..... (relation to the insured) Mr./Miss./Master ..... I further declare that his/her receipt shall be sufficient discharge to the company.

I further declare that and warrant that the above statements are true and complete. I consent to the insured seeking medical information from any doctor who has at any time attended concerning anything which affects my physical or mental health, and I authorize the giving such information to Mercury International Assistance & Claims LTD, and / or their programme medical advisers. I agree that this proposal shall form the basis of the contract should the insurance be effected.

I am willing to accept the policy, subject to the terms, exceptions and conditions prescribed therein.

Signature of Proposer Date ...../...../.....
Day Month Year

Place :

B) TO BE COMPLETED BY THE DOCTOR (To be completed by M.D. only)

1. a) History
   b)Any past history of disease, operation, accidents, investigation, etc.
   c)General Examination
   d)Systemic Examination

2. Electrocardiography:

   a) Does the attached electrocardiogram in your professional opinion show any Abnormalities if so, please describe :
   b) Does the abnormality represent a current illness or disease which may possibly Require medical treatment during proposerôs forthcoming trip?
   c) Does the proposer now or did he/she in the past, require medication for this abnormality
   d) Please describe any treatment taken by Proposer in the past or being taken at present
   e) Do you recommend Stress Test? If so please obtain the report on such test

3. Does the Blood/Urine test show any sugar?

4. Do you consider that Proposer is to fit to travel anywhere abroad, due account being taken of the stress of air travel adversely affecting his health/medical condition?

Signature of the Doctor :

Name of the Doctor :

Qualification :

Address :

Telephone No. :