MAX Bupa HEALTH INSURANCE

Health Companion Proposal Form

Notes:

1. This form is to be completed by the PROPOSER only.
2. Please ensure that the details provided in the proposal form are correct. If the information provided is incorrect or incomplete, Max Bupa Health Insurance Company Limited (the Company) may not accept liability for claims made under the policy.
3. Please complete this form in CAPITAL LETTERS for self and each applicant (proposed insured person).
4. If you require additional space to answer any question on this Proposal Form, please attach additional sheets of paper and indicate on the additional sheet the question number to which the information being provided pertains.

1. Proposer Details

Title

Name

DOB D D M M Y Y Y Y Gender Male Female Other

Current address

Landmark City

District State

Pin code Landline number

Mobile number Alternate number

Email ID

Aadhar Number (Mandatory)

PAN Number (Mandatory for premium above Rupees 1 lac)

Nationality Annual income (Rs)

Employment: Salaried Self-employed Student Housewife Other, please specify _____

Premium paid by Relationship with Proposer

Are you a PEP[#]? Yes No Do you fall under social sector[$]? Yes No If Yes, please tick the relevant option

a. Unorganized sector

b. Informal sector

c. Economically vulnerable or backward classes

d. Other categories of persons

'Social sector' includes unorganized sector, informal sector, economically vulnerable or backward classes and other categories of persons, both in rural and urban areas.

a. 'Unorganized sector' includes self-employed workers such as agricultural labourers, bidi workers, brick kiln workers, carpenters, cobblers, construction workers, fishermen, hamals, handicraft artisans, handloom and khadi workers, lady tailors, leather and tannery workers, papad makers, powerloom workers, physically handicapped self-employed persons, primary milk producers, rickshaw pullers, safai karmacharis, salt growers, sericulture workers, sugarcane cutters, tendu leaf collectors, toddy tappers, vegetable vendors, washerwomen, working women in hills, or such other categories of persons;

b. 'Informal sector' includes small scale, self-employed workers typically at a low level of organization or technology, with the primary objective of generating employment and income, with heterogeneous activities like retail trade, transport, repair and maintenance, construction, personal and domestic services and manufacturing, with the work mostly labour intensive, having often unwritten and informal employer-employee relationship;

c. 'Economically vulnerable or backward classes' means persons who live below the poverty line;

d. 'Other categories of persons' includes persons with disability as defined in the Persons of Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 and who may not be gainfully employed; and also guardians who need insurance to protect spastic persons or persons with disability.

Bank details:

Bank name

Branch

City

Account number

IFSC Code

Account type: Savings Current

Details of Electronic Insurance Account (eIA)

Do you wish to have this policy credited to an e-Insurance account? (Please select any one)

No ☐ I do not have an e-insurance account and do not wish to open one

Yes ☐ Credit this policy to my e-Insurance account

If Yes, Please share existing E-Insurance Account No. ☐

Please select Insurance Repository Name (you have opened your account with)

1. NSDL ☐ 2. CIRL ☐ 3. KARVY ☐ 4. CAMS ☐ (Please select any one)

Or

I do not have existing e-Insurance account and I am interested in creating a new e-Insurance account (Please submit electronic insurance account opening form (eIA form) along with relevant documents). ☐

2. Coverage Selection:

Are you applying for portability: ☐ Yes ☐ No (If Yes, please fill the separate portability form also).

Please tick the relevant boxes:

Base coverage:

Plan type: ☐ Variant 1 ☐ Variant 2 ☐ Variant 3 ☐ Family First

Policy type: ☐ Individual ☐ Family Floater

Number of lives to be covered: Adults ☐☐☐☐☐☐ Children ☐☐☐☐☐☐

Policy term: ☐ 1 Year ☐ 2 Year

Coverage for Individual or Family Floater policy type: Base Sum Insured ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Coverage for Family First plan type: Base Sum Insured ☐☐☐☐☐☐☐☐ Floater Sum Insured ☐☐☐☐☐☐☐☐

Annual Aggregate Deductible: ☐ Yes ☐ No If yes, then please choose the deductible amount:

☐ Rs. 1 lac ☐ Rs. 2 lac ☐ Rs. 3 lac ☐ Rs. 4 lac ☐ Rs. 5 lac ☐ Rs. 10 lac

Optional coverage under the product:

Hospital Cash ☐ Yes ☐ No

For Individual/Family Floater policy type: Rs 1,000 per day (for Variant 1), Rs 2,000 per day (for Variant 2) & Rs 4,000 per day (for Variant 3)

If yes, then please choose for Family First plan from one of the options below: Rs 1,000 per day ☐ Rs 2,000 per day ☐

3. Details of Applicants for Insurance

Applicant No. 1

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Applicant No. 3

Name

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y

Relationship with Proposer (Please tick option) Self/Spouse/ Son/Daughter-in-Law/ Daughter/Son-in-law/ Father/ Mother/Father-in-law

Mother-in-law/ Grandfather/ Grandmother/Grandson/Granddaughter/ Brother/Sister/ Sister-in-law/ Brother-in-law/ Nephew/ Niece

Please tick if not Indian ☐ Please tick if PEP# ☐

Applicant No. 4

Name

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y

Relationship with Proposer (Please tick option) Self/Spouse/ Son/Daughter-in-Law/ Daughter/Son-in-law/ Father/ Mother/Father-in-law

Mother-in-law/ Grandfather/ Grandmother/Grandson/Granddaughter/ Brother/Sister/ Sister-in-law/ Brother-in-law/ Nephew/ Niece

Please tick if not Indian ☐ Please tick if PEP# ☐

Applicant No. 5

Name

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y

Relationship with Proposer (Please tick option) Self/Spouse/ Son/Daughter-in-Law/ Daughter/Son-in-law/ Father/ Mother/Father-in-law

Mother-in-law/ Grandfather/ Grandmother/Grandson/Granddaughter/ Brother/Sister/ Sister-in-law/ Brother-in-law/ Nephew/ Niece

Please tick if not Indian ☐ Please tick if PEP# ☐

Applicant No. 6

Name

Gender ☐ Male ☐ Female ☐ Other Height ☐☐ (ft) ☐☐ (inch) Weight ☐☐☐ (kg)

Waistline ☐☐ (inch) Date of Birth D D M M Y Y Y Y

Relationship with Proposer (Please tick option) Self/Spouse/ Son/Daughter-in-Law/ Daughter/Son-in-law/ Father/ Mother/Father-in-law

Mother-in-law/ Grandfather/ Grandmother/Grandson/Granddaughter/ Brother/Sister/ Sister-in-law/ Brother-in-law/ Nephew/ Niece

Please tick if not Indian ☐ Please tick if PEP# ☐

#Politically Exposed Persons (PEP) are individuals who are or have been entrusted with prominent public functions i.e. Heads / Ministers of Central or State Government, Senior Politicians, Senior Government, Judicial or Military officials, Senior Executives of Government companies, important party officials. (If you have ticked against PEP, kindly fill the separate PEP questionnaire.)

4. Nomination

In the event of the death of the Proposer, any payment due under the Policy shall become payable to the Nominee named below. The receipt of such payment by the Nominee would constitute discharge of the Company's liability under the Policy. Nominee for all other applicant(s) shall be the Proposer himself / herself.

Nominee Name	Date of Birth	Relationship with the Proposer	Address and contact details of Nominee	Appointee Name (if nominee is less than 18 years of age)

5. Medical Habits and Family History

SECTION A: Please answer questions A to D by circling Yes (Y) or No (N). Provide details of any disclosure made in Section B
(Note - These questions are not applicable for maternity, please refer to Section E only for answering questions related to maternity)

	Applicant Number											
	1		2		3		4		5		6	
A. Is the applicant currently suffering from any symptom(s) or complaint(s) persisting from more than five consecutive days for which he/she has **not** consulted a doctor?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
B. Other than routine health check-up, has the applicant undergone or been advised to undergo any diagnostic test/investigation **including but not limited** to Thyroid Profile, Treadmill test, Angiography, Echocardiography, Endoscopy, Ultrasound, CT Scan, MRI, Biopsy and FNAC?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

C. Has the applicant been prescribed or taken any form of treatment or medication (including oral / inhalation / injection), for a period of more than seven days?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
D. Has the applicant undergone or been advised to undergo or does he/she plan to undergo any form of surgery or procedure?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

SECTION B: If you have answered Yes (Y) to any question in Section A, please tick the relevant box(es) below, corresponding to the type(s) of disorder and/or body system(s) affected.

	Applicant Number					
	1	2	3	4	5	6
Cancer & related disorders Benign/malignant tumour, leukaemia, lumps, swelling, mass, cysts, changes in mole, etc.						
Kidney, urinary and prostate disorders Stones, sugar / albumin / blood in urine pain /difficulty in urination, dialysis, kidney failure, etc.						
Heart and circulatory system related disorders Swelling of leg (s), painful / visible leg veins, high cholesterol, chest pain, breathlessness on exertion, palpitations, loss of consciousness, angina, heart-attack, etc.						
Lung and respiratory disorders Persistent hoarseness / cough, difficulty in breathing, asthma, chronic bronchitis, tuberculosis, any lung infection, etc						
Stomach, intestine, liver, gall bladder, pancreas, appendix disorders Stones, persistent stomach pain, sudden loss of weight, hemorrhoids, ulcer, blood in vomiting or stool, painful defecation, ulcerative colitis, Crohn's disease, jaundice, hepatitis, pancreatitis, appendicitis, etc.						
Psychiatric and nervous disorders (brain/spine) Sudden loss of consciousness, decrease in strength / movement of limbs, paralysis, loss of speech or memory, tremors, stroke, seizure / epilepsy / fits, Parkinsonism, Alzheimer's, etc.						
Endocrine disorders Abnormal thyroid function, goitre, hypothyroidism, impaired glucose tolerance test, abnormal HbA1c, abnormal growth hormone function, etc.						
Bone and muscle disorders Arthritis, ligament / cartilage tear, bone fracture or pain, chronic joint / muscle pain, gout, sciatica, etc.						
Ear, nose, eye and throat disorders Recurrent ear discharge, polyp, persistent sinusitis, hearing loss, vision problem, nasal septum disorders, laryngitis / adenoiditis / tonsillitis, etc						
Gynaecological disorders Fibroid, cyst, menstrual disorder, pelvic infection, breast lump / mass, endometriosis, etc. **(Use Section E for pregnancy / maternity)**						
Blood-related disorders HIV / AIDS, anaemia, thalassaemia, haemophilia or any other blood related problem.						
Skin disorders Psoriasis, leucoderma, eczema, dermatitis, erthyema, vitiligo, etc.						
Any other conditions						

	Applicant Number											
	1		2		3		4		5		6	
SECTION C: Does the applicant have diabetes or pre-diabetes or has he/she EVER had high blood sugar? Please circle Yes (Y) or No (N)	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
If Yes (Y), then please tick the relevant option(s) below:												
How does the applicant manage his/her diabetes / pre-diabetes / high blood sugar?												
A. Insulin	☐		☐		☐		☐		☐		☐	
B. Oral diabetic medication	☐		☐		☐		☐		☐		☐	
C. Homeopathic or other AYUSH treatment	☐		☐		☐		☐		☐		☐	
D. No medicine	☐		☐		☐		☐		☐		☐	

How long ago was the applicant first diagnosed with diabetes / pre-diabetes / high blood sugar?							
A. 0-1 years							
B. 1-5 Years							
C. 5-10 years							
D. More than 10 Years							

	Applicant Number											
	1		2		3		4		5		6	
SECTION D: Does the applicant have Hypertension or High Blood Pressure? Please circle Yes (Y) or No (N)	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
If Yes (Y), then please tick the relevant option(s) below:												
How does the applicant manage his/her Hypertension / High Blood Pressure?												
A. One medicine												
B. Two medicines												
C. Three or more medicines												
D. No medicine												
How long ago was the applicant first diagnosed with Hypertension / High Blood Pressure?												
A. 0-1 years												
B. 1-5 Years												
C. 5-10 years												
D. More than 10 Years												

SECTION E: To be answered for all female applicants who have EVER been pregnant. Please answer the below questions by circling Yes (Y) or No (N).

	Applicant Number											
	1		2		3		4		5		6	
A. Currently pregnant	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
B. Undergone caesarian section or premature delivery	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
C. Undergone abnormal or complicated pregnancy	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
D. Undergone abortion	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Please specify the number of pregnancies (if any)												
Please specify the number of live births (if any)												

SECTION F: For questions marked Yes (Y) in Section A, C, D or E, please specify following information:

Applicant Number	Details of symptom(s) or investigation(s) or diagnosis or procedure/ surgery undergone		Duration of condition	Medication(s)	Dosage	Current status (e.g. Complete / partial recovery or ongoing treatment)	Treating doctor's name & contact details	Documents attached (Yes/No)
	Details	Onset date						

SECTION G: Please share information on habits												
	Applicant Number											
	1		2		3		4		5		6	
Does the applicant consume any of the following, please answer the below questions by circling Yes (Y) or No (N).												
A. Chewable tobacco / Gutkha / Pan Masala	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
If Yes(Y), please specify consumption in number of pouches per week:												
B. Alcohol	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
If Yes(Y), please specify per week consumption of the following:												
-Beer (Number of pints per week)												
-Wine (Number of glasses per week)												
-Spirit (ml per week)												
C. Cigarettes / Bidi / Cigar	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
If Yes (Y), please specify per week consumption:												
D. Illicit drugs	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
If Yes (Y), please specify per week consumption:												

SECTION H: Family History

Have any first degree relatives (i.e. parents, brothers, sisters or children) of ANY of the applicants (who are not themselves applicants for this insurance policy) had cancer, diabetes, hypertension (high blood pressure), heart disease, kidney disease, polycystic kidney disease, mental or nervous disorder (including alzheimer's disease), stroke, multiple sclerosis, motor neurone disease or any other hereditary disorders?

Yes ☐ No ☐ If Yes, then please fill the below details:

Applicant Number	Relationship to the applicant	Disease or disorder	Age of the affected family member			Cause of death (if applicable)
			at onset of condition	current age (if alive)	at death (if applicable)	

6. Family Physician Details

Applicant No.	Family physician name	Contact number 1	Contact number 2

7. Other Health Insurance

Are you or any other applicant currently insured under another health insurance policy with the Company or any other insurance company?

☐ Yes ☐ No If Yes, then please fill the below details:

Applicant Number	Insurance Company Name	Policy Number/ Application Number	Insured from (Date)	Insured till (Date)	Sum Insured	Please tick if a claim for health benefits has been made
						☐
						☐

Please provide details of any claims on a separate sheet, including the reason for the claim, amount claimed and whether the claim was paid by the insurer or not.

8. Past Proposals

Has any proposal for life, health, hospital daily cash or critical illness insurance on the life of the applicant ever been declined, postponed, loaded or been made subject to any special conditions such as exclusions by any insurance company?	Applicant Number											
	1		2		3		4		5		6	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

9. Authorization for Electronic Policy Fulfillment and Service Communications

Would you like to protect the environment and help save paper by authorizing the Company to send all my policy and service related communication to the email ID as mentioned here in the application form? ☐ Yes ☐ No

10. Renewal Payment Sign-up

Payment of renewal premium of your health insurance policy can be made every year through continuing your existing Automated Clearing House (ACH) / Standing Instructions (SI) with the Company. Under this option, your policy can be renewed promptly, but subject to you completing all additional requirements of information and documentation as may be required by the Company.

☐ I want to opt for the ACH/SI renewal option.

11. Declaration (Please read carefully and put a check mark against each before signing)

☐ I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorized to propose on behalf of these other persons.

☐ I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable.

☐ I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

☐ I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

☐ I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory Authority.

Dated D D M M Y Y Y Y Place _____ Signature of the Proposer _____

12. Vernacular Declaration

(Certification in case the Proposer has signed in vernacular (to be witnessed by someone other than agent/ employee of the Company))
The content of this form and its particulars have been explained by me in vernacular to the Proposer who has understood and confirmed the same:

Name of the Witness _____ Signature of the Witness _____ Signature of the Proposer _____

13. Proposer Declaration

(Certification where for any reason, the proposal and other connected papers are not filled in by the prospect).
The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract. The Proposal Form is filled by _____ under my instruction and I found it to be correct.

Signature of the Proposer _____

Product Name: Health Companion, Product UIN No.:IRDAI/HLT/MBHI/P-H/V.III/2/2017-18

14. Acknowledgment by the Company

Application No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date D D M M Y Y Y Y

We acknowledge with thanks the receipt of your proposal and amount by Cheque/Demand Draft/ Others _____

of amount of Rs. ☐☐☐☐☐☐☐☐ Dated D D M M Y Y Y Y Drawn on ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Neither the submission to us of a completed proposal for Insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for Insurance, it shall be subject to the policy terms and conditions and we shall have no liability whatsoever if premium is not received by us in full and in time or is not realized. If we do not accept the proposal, we will inform you and refund the payment after deducting cost of medical tests. if any, received from you without interest.

Signature of the receiver and office seal

15. Premium details (for office use only)

Premium payment option ☐ Cheque ☐ Demand Draft ☐ Credit card Premium amount

Online payment transaction ID: Date: D D M M Y Y Y Y

Bank name/ branch

For Credit/Debit card: (Payment to be collected only from Proposer's card / bank account)

Card No. Expiry date M M Y Y

Card type (Please tick) Visa/Master/Amex

Name on the card

Max Bupa branch location

Code No.

Business sourced by: Advisor/DST/Corporate Agency/ other channels Code No

Name

Proposal received on:

Customer ID:

16. Additional details for Bancassurance channel only (for office use only)

Branch Code SP Code RM/LG code

Customer Account Number

17. Insurance Advisor's Report (for office use only)

1.Are you related to the Proposer? Yes/No; If yes, nature of relationship?

2.For how long have you known the Proposer? Years Months

3.Are you satisfied with the identity of the Proposer? ☐ Yes ☐ No

4.Does the Proposer or any applicant have any physical deformity/defect or mental retardation? ☐ Yes ☐ No

5.Have you explained the exclusions of the policy and has the Proposer personally completed the health declaration? ☐ Yes ☐ No

6.What is the Proposer's state of health at the time of making of this proposal form?

7.Do you recommend acceptance of this proposal form considering all the factors including moral hazard? ☐ Yes ☐ No

8.Have you dispassionately advised the Proposer and provided all material information to enable the Proposer to decide in the best cover that would be in his / her interest? ☐ Yes ☐ No

Date D D M M Y Y Y Y Signature of the Insurance Advisor _____

18. Statutory Warning

Prohibition of Rebates (Under Section 41 of the Insurance Act 1938)

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 of 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 published prospectuses or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Max Bupa Health Insurance Company Limited. Corporate Office: B-1/1-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi-110044. Registered Office: Max House 1, Dr. Jha Marg, Okhla, New Delhi - 110020. Website: www.maxbupa.com, Fax: 011-30902010, Customer Helpline No.: 1860-500-8888. CIN: U66000DL2008PLC182918, IRDAI Registration No. 145. 'Max', 'Max logo', 'Bupa' and HEARTBEAT logo are owned by Max and Bupa and used under license by us. Insurance is the subject matter of solicitation. Please read sales brochure carefully before concluding a sale.

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Key Feature Document

Max Bupa is dedicated towards being fair and transparent with its customers. This document summarizes key features and waiting periods in your policy. Please read it carefully to understand your policy better.

2 Year Specific waiting period: Few conditions (such as Cataract, Hernia, Chronic kidney disease and Diabetes etc.) will be subject to a waiting period of 24 months from the date of commencement of the first Policy Period of the insured person and subject to continuous renewal.

Pre Existing Disease (P.E.D): Any condition/ illness/ injury which the insured person has suffered from before issuance of policy is classified as P.E.D Claims with respect to P.E.D are not payable till the completion of waiting period i.e. 48 months in case of Variant 1 and 36 months in case of Variant 2, Variant 3 and Family First, since inception of the policy and continuous renewal.

Room rent/hospital accommodation: covered up to Sum Insured (except for suite or above room category)

No Claim Bonus: If you do not claim in any policy year, we increase your sum insured by 20% of base sum insured subject to a maximum of 100% of the base sum insured.

Health Check-up: We offer free Health Check-up for all adult insured members, applicable once in 2 years for Variant 1 and Annual for Variant 2, Variant 3 and Family First plan, upon renewal of your Policy.

Refill Benefit: Refill benefit is (up to Base Sum Insured) available only under Individual and Family Floater Plans. Family First plan does not have Refill benefit.

Alternative Treatment: We will cover medical expenses for Ayurveda, Unani, Sidha and Homeopathy (AYUSH) taken in government hospital or in any institute recognized by the government and /or accredited by the Quality Council of India.

Top Up plan on Annual Aggregate Basis: If this option is opted, then your claims would become payable only when total claims in the policy year exceeds the chosen deductible amount.
For eg: Assuming you choose deductible amount as Rs.1 lakh with base sum insured of Rs.5 lakh. Your 1 claim in the policy year is Rs.50,000, the claim will not be payable as it is less than your chosen deductible amount. If you claim again in the same policy year for Rs.75,000 then we will settle your claim only up to Rs.25,000 as your total claim exceeding Rs.1 lakh in the same policy year is Rs.25,000

Portability Benefits: Waiver of waiting period(s) is provided to the extent of period and Sum Insured already covered continuously and without a break with any previous Indian retail health insurance policy as Insured, based on portability guidelines.

Rise in Premium with Age: Your health insurance premium will increase gradually every year as insured person(s) age increases.

Member addition/deletion: Any addition or deletion of the member(s) in the policy can be done only at the time of renewal.

Pre Policy Medical Check-up (PPMC) Cost: In case the proposal is declined for Policy Issuance, customer will have to bear 100% of the cost incurred towards PPMC.

Free Look Provision: If you do not agree to the terms and conditions of the policy, you may cancel the policy stating reasons within 15 days of receipt of the policy document provided no claim(s) have been made. Premium shall be refunded post deducting charges for medical checkup, stamp duty and proportionate risk premium for the period on cover. The free look provision is not applicable at the time of Renewal of the Policy.

NOTE: These are only summary of the covers offered. Please refer to the policy wordings for complete details before concluding the sale; this document is only an indicator for key benefits in the policy. Kindly deposit the premium amount through a secured mode of payment in the name of MAX BUPA HEALTH INSURANCE COMPANY LIMITED.

___I hereby consent to and authorize the Company to make welcome calls, service calls or any other communication (electronic or otherwise) with respect to the proposed or existing policy of Company from time to time.

Date:_____ Signature of Proposer:_____

Place:_____ Name of Proposer:_____

Max Bupa Health Insurance Company Limited. Corporate Office: B-1/1-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi-110044. Registered Office: Max House 1, Dr. Jha Marg, Okhla, New Delhi - 110020. Website: www.maxbupa.com, Fax: 011-30902010, Customer Helpline No.: 1860-500-8888. CIN: U66000DL2008PLC182918, IRDAI Registration No. 145. 'Max', 'Max logo', 'Bupa' and HEARTBEAT logo are owned by Max and Bupa and used under license by us. Insurance is the subject matter of solicitation. Please read sales brochure carefully before concluding a sale.

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