



**THE NEW INDIA ASSURANCE CO. LTD.,**  
Regd. & Head Office: 87, M.G. Road, Fort, Mumbai- 400 001.

Med - 02

**PROPOSAL FORM FOR MEDICLAIM POLICY (2007)**

Please read the prospectus before filling up this form.

A) The Company shall not be on risk until the proposal has been accepted by the Company and communications of acceptance has been given to the proposer in writing on full payment of premium.

B) For persons above 45 years of age or persons below 45 years of age, having adverse medical history declared in the proposal form will have to undergo, pre-acceptance health check up at a designated hospital/nursing home. The Divisional Office/Branch Office in the name of hospital/Nursing home will give a referral slip for conducting the pre-acceptance health check up. The details of the check up to be done are available with the Divisional Office/Branch Office.

C) If other family members residing with proposer i.e. spouse, eligible dependent children and dependent parents and dependent parents in law are required to be covered, complete details of each person should be furnished. Two Stamp size photograph of each person are to be submitted, one of which is to be affixed on the proposal.

D) Fresh proposal form is required along with pre acceptance medical check up as mentioned in item (B) above, irrespective of age, when there is break in insurance cover **or** when there is request for enhancement in the sum insured.

**E) Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy.**

1. NAME OF PROPOSER : Mr/Mrs. \_\_\_\_\_

2. RESIDENTIAL  
ADDRESS: \_\_\_\_\_

Tel.No: \_\_\_\_\_ Fax No. \_\_\_\_\_ E-Mail: \_\_\_\_\_

3. Occupation: \_\_\_\_\_

4. Average Monthly Income Rs. \_\_\_\_\_ Income Tax PAN No: \_\_\_\_\_

5. NAME, ADDRESS & TEL.NO: OF FAMILY PHYSICIAN \_\_\_\_\_

QUALIFICATION: \_\_\_\_\_ REGN .NO: \_\_\_\_\_

6. Are you a member of Recognized Health Club/Gymnasium: \_\_\_\_\_

If yes, then submit proof of your membership \_\_\_\_\_

7. Are you at present or have you been at any other time in the past covered under any other Insurance (PA, Cancer Insurance, Hospitalization Insurance or other Medical Insurance). If so, give particulars of:

1. Name of Insurer,
2. Policy No.
3. Period of cover
4. Claim Amt. Recd./receivable