Health Companion Health Insurance Plan Proposal Form

MAX Bupa HEALTH INSURANCE

Please fill up this form in CAPITAL LETTERS for yourself and each proposed insured person.

1. Proposer Details

Title

Name First Name | Middle Name | Last Name

Permanent Address

City **District**

State **Pin code**

Current Address

City **District**

State **Pin code**

Address for Communication ☐ Permanent ☐ Current

Phone No. STD Code Landline No. Mobile No.

E-mail ID

(Atleast one of mobile number and email id is mandatory)

PAN No. (Mandatory for premium above Rupees One Lac)

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated

Nationality

Educational Qualification ☐ Lesser than matriculation ☐ Matriculation ☐ Graduate ☐ Post-graduate ☐ Professional course

Occupation ☐ Salaried ☐ Self employed ☐ Student ☐ House wife ☐ Others

If Salaried, specify designation

If self employed, specify business/occupation

Annual Gross Income (in Rs.)

Bank Details:

Bank Name

Branch

City

Account Number

Account Type ☐ Savings ☐ Current IFSC Code

2. Coverage Selection: Section I

1. Plan Details

Policy Type ☐ Individual ☐ Family Floater ☐ Family First

If family floater, number of persons to be covered

☐ 1 Adult + 1 Child ☐ 1 Adult + 2 Children ☐ 1 Adult + 3 Children
☐ 1 Adult + 4 Children ☐ 2 Adults ☐ 2 Adults + 1 Child
☐ 2 Adults + 2 Children ☐ 2 Adults + 3 Children ☐ 2 Adults + 4 Children

If family first number of persons to be covered _____ Adults _____ Children.

2. Proposed Policy term ☐ 1 Year ☐ 2 Year

Please tick/fill the relevant boxes.

3. Sum Assured (In Rupess)

3.1 Individual/Family

Variant 1	Variant 2	Variant 3
2Lac 3Lac 4Lac	5Lac 7.5Lac 10Lac 12.5Lac	15Lac 20Lac 30Lac 50Lac 1Cr

3.2 Family First

Individual Sum Insured: 1Lac, 2Lacs, 3Lacs, 4Lacs, 5Lacs, 10Lacs

Floater Sum Insured: 3Lacs, 4Lacs, 5Lacs, 10Lacs, 15Lacs, 20Lacs

Please tick the relevant boxes.

Details of Persons Proposed to be Insured

Proposed Insured 1

Title

Name First Name Middle Name Last Name

Gender Male Female **Height** (cm) **Weight** (Kg) **Date of Birth** DD MM YYYY

Relationship with Proposer Self Spouse Son Daughter Other

Educational Qualification Non-matric Matric Graduate Post-graduate Professional course

Occupation Salaried Self employed Student House wife Others **Waistline (cm)**

If salaried, specify designation

If self employed, specify business/occupation

Proposed Insured 2

Title

Name First Name Middle Name Last Name

Gender Male Female **Height** (cm) **Weight** (Kg) **Date of Birth** DD MM YYYY

Relationship with Proposer Self Spouse Son Daughter Other

Educational Qualification Non-matric Matric Graduate Post-graduate Professional course

Occupation Salaried Self employed Student House wife Others **Waistline (cm)**

If salaried, specify designation

If self employed, specify business/occupation

Proposed Insured 3

Title

Name First Name Middle Name Last Name

Gender Male Female **Height** (cm) **Weight** (Kg) **Date of Birth** DD MM YYYY

Relationship with Proposer Self Spouse Son Daughter Other

Educational Qualification Non-matric Matric Graduate Post-graduate Professional course

Occupation Salaried Self employed Student House wife Others **Waistline (cm)**

If salaried, specify designation

If self employed, specify business/occupation

Proposed Insured 4

Title

Name First Name Middle Name Last Name

Gender Male Female **Height** (cm) **Weight** (Kg) **Date of Birth** DD MM YYYY

Relationship with Proposer Self Spouse Son Daughter Other

Educational Qualification Non-matric Matric Graduate Post-graduate Professional course

Occupation Salaried Self employed Student House wife Others **Waistline (cm)**

If salaried, specify designation

If self employed, specify business/occupation

Proposed Insured 5

Title

Name First Name | Middle Name | Last Name

Gender ☐ Male ☐ Female **Height** (cm) **Weight** (Kg) **Date of Birth** DD MM YYYY

Relationship with Proposer ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____

Educational Qualification ☐ Non-matric ☐ Matric ☐ Graduate ☐ Post-graduate ☐ Professional course

Occupation ☐ Salaried ☐ Self employed ☐ Student ☐ House wife ☐ Others **Waistline (cm)** _____

If salaried, specify designation

If self employed, specify business/occupation

Proposed Insured 6

Title

Name First Name | Middle Name | Last Name

Gender ☐ Male ☐ Female **Height** (cm) **Weight** (Kg) **Date of Birth** DD MM YYYY

Relationship with Proposer ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____

Educational Qualification ☐ Non-matric ☐ Matric ☐ Graduate ☐ Post-graduate ☐ Professional course

Occupation ☐ Salaried ☐ Self employed ☐ Student ☐ House wife ☐ Others **Waistline (cm)** _____

If salaried, specify designation

If self employed, specify business/occupation

Proposed Insured 7

Title

Name First Name | Middle Name | Last Name

Gender ☐ Male ☐ Female **Height** (cm) **Weight** (Kg) **Date of Birth** DD MM YYYY

Relationship with Proposer ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____

Educational Qualification ☐ Non-matric ☐ Matric ☐ Graduate ☐ Post-graduate ☐ Professional course

Occupation ☐ Salaried ☐ Self employed ☐ Student ☐ House wife ☐ Others **Waistline (cm)** _____

If salaried, specify designation

If self employed, specify business/occupation

Proposed Insured 8

Title

Name First Name | Middle Name | Last Name

Gender ☐ Male ☐ Female **Height** (cm) **Weight** (Kg) **Date of Birth** DD MM YYYY

Relationship with Proposer ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____

Educational Qualification ☐ Non-matric ☐ Matric ☐ Graduate ☐ Post-graduate ☐ Professional course

Occupation ☐ Salaried ☐ Self employed ☐ Student ☐ House wife ☐ Others **Waistline (cm)** _____

If salaried, specify designation

If self employed, specify business/occupation

Proposed Insured 9

Title

Name First Name | Middle Name | Last Name

Gender ☐ Male ☐ Female **Height** (cm) **Weight** (Kg) **Date of Birth** DD MM YYYY

Relationship with Proposer ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____

Educational Qualification ☐ Non-matric ☐ Matric ☐ Graduate ☐ Post-graduate ☐ Professional course

Occupation ☐ Salaried ☐ Self employed ☐ Student ☐ House wife ☐ Others **Waistline (cm)** _____

If salaried, specify designation

If self employed, specify business/occupation

4. Nomination

In the event of the death of the proposer any payment under policy shall become payable to the nominee proposed in form subject to any change in nomination as per the terms of the policy and the recipt of the proceeds by such nominee would be sufficient discharge to the company.Nominee for all other persons proposed to be insured shall be the proposer himself/herself. Following section to be filled by the proposer.

Nomination Name	**Relationship with the proposer**	**Address and contact details of Nominee**
First Name _____		Address _____
Middle Name _____		_____
Last Name _____	_____	Phone number _____

5. Medical History

In order for us to service you fully, please answer the questions below accurately to the best of your knowledge in respect of each person proposed to be insured. Please ensure that you are fully informed about the standard waiting periods and permanent exclusions that apply to the Max Bupa Health Insurance policies.

Questions	Proposed Insured 1 Name		Proposed Insured 2 Name		Proposed Insured 3 Name		Proposed Insured 4 Name		Proposed Insured 5 Name		Proposed Insured 6 Name	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1) Within the last 2 years, have you consulted a doctor or a healthcare professional?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2) Have you ever been to a hospital for an operation and/or an investigation (e.g. scan, x-ray, biopsy of blood tests)? (Other than Preventive Health Check-up or pre Employment Check-up)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3) Do you take tablets, medicines or drugs on a regular basis?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4) Within the last 3 months have you experienced any health problems or medical conditions which you/proposed insured have/has not seen a doctor for?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Note: In addition to the above, we may have additional questions for you or may ask you to undergo medical tests to complete your full medical assessment.

6. Does any person proposed to be insured consume any of the following:

Substance		**Insured #1**	**Insured #2**	**Insured #3**	**Insured #4**	**Insured #5**	**Insured #6**
Alcohol	Yes/No						
	Quantity$						
	No. of Years						
If this habit has been in the past, please mention	The year of stopping it & the reason for doing the same habit						
Smoking	Yes/No						
	Quantity$						
	No. of Years						
If this habit has been in the past, please mention	The year of stopping it & the reason for doing the same habit						
Any other substance like Tobacco/Guthka/ Pan/Pan Masala etc	Yes/No						
	Quantity$ (Pouch/day)						
	No. of Years						
If this habit has been in the past, please mention	The year of stopping it & the reason for doing the same habit						
Narcotics	Yes/No						
	Quantity$						
	No. of Years						
If this habit has been in the past, please mention	The year of stopping it & the reason for doing the same habit						

($: Beer - No. of Pints per day, wine & Sprit - ml/day, No. of Cigarettes)

7. Additional Information

If you have answered yes to any of the questions in Section 5, please give full details here. If you need more space please use extra sheets. If you are unsure whether any details are relevant, please include them.

Name of proposed insured	The relevant question number from section 5 (Medical History)	Please specify as accurately as possible the symptoms or the medical condition. Where applicable, please state the area of the body affected (e.g. right leg, left eye).	When did the symptoms start and/or when was the treatment completed?	What treatment did you receive and when (please include dates of treatment and any medication prescribed)?	What was the outcome of the treatment (e.g. ongoing, complete recovery, recurrent or likely to recur)?

The following is an outline of the permanent exclusions under the Policy. For further details on the exclusions, please refer to the terms and conditions of the policy.

Addictive conditions and disorder; Aging and puberty; Artifical life maintenance; circumcision; Dental/oral treatment; Conflict and disaster' Congenital conditions; Convalesscence and Rehabilitation; Cosmetic surgery; Drugs and dressings for OPD Treatment or take-home use; Eyesight; Unproven/Experimental treatment; psychiatric and Psychosomatic Condition; OPD Treatment, Stem cell implantation, Ancillary Hospital charges; for medical papers; Treatment for Alopecia; Unrelated diagnostic, x-ray or laboratory examinations; Charges for medical papers; Reproductive medicine; Self-inflicted injuries; Sexual problems and gender issues; Sexually transmitted diseases; Unrecognized physician or Hospital ; Sleep disorders; Speech Treatment for developmental problems; Treatment recived outside India; Hospitalization undertaken for observation or for investigation only and where no medical to para-jumping, rock climbing, mountaineering, motor racing, horse racing or deep-sea diving.: unlawful Activity; Any costs or expenses specified in the List of Expenses Generally Excluded at Annexure I

For all Insured Persons from commencement of the first Policy Period, the conditions listed below will be subject to a waiting period of 24 months and will be covered from the commencement of the third Policy Year as long as the insured Person has been insured continuously under the Policy without any break.
• Stones in biliary and urinary systems • Lumps / cysts / nodules / polyps / internal tumours • Gastric and Duodenal Ulcers • Surgery on tonsils / adenoids • Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse • Cataract • Fissure / Fistula / Haemorrhoids • Hernia / Hydrocele • Chronic Renal Failure or end stage Renal Failure • Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media • Benign Prostatic Hypertrophy • Knee/Hip Joint replacement • Dilatation and Curettage • Varicose veins • Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis • Diabetes and related complications • Hysterectomy for any benign disorder

There could be certain declined risks as per underwriting norms of the company.
Based on the assessment of your health some conditions may have personal waiting periods or exclusions applicable to any / all of the proposed insured.

Please Note: To help us serve you better, we request you to notify us in writing within 48 hours of admission to the hospital or before discharge from the Hospital, for all Hospitalizations which have not been pre authorized by us. The notification should be ideally provided by the Policy holder/Insured Person In the event Policy holder and Insured Person is unwell, then the notification should provided by any immediate adult member of the family.

I/We hereby declare, on my 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/we am/are authorized to propose on behalf of these other persons.

Coverage Selection: Section II

1. Do you want to apply for a **Hospital Cash benefit?**

☐ Yes ☐ No

Please note that the Hospital Cash daily limit for your policy would be as per the following table,

Base Plan opted for in Section I	Hospital Cash
Variant 1	Rs 1,000/day
Variant 2	Rs 2,000/day
Variant 3	Rs 4,000/day

For Family First Variant (Please tick the relevant box)	Hospital Cash
☐	Rs 1,000/day
☐	Rs 2,000/day

2. Tiered Network - Cashless Hospital Network option

a. Do you reside in any of the following cities or their sub-urban areas: Delhi/NCR, Mumbai (inc. Thane and Vashi), Bengaluru, Chennai, Surat, Pune, Hyderabad, Kolkata and Ahmedabad.

☐ Yes ☐ No

b. If answer to 2. a. is "No" then please choose from one of the options below

Option 1	National Network: All Max Bupa network hospitals	
Option 2	Local Network: National Network excluding hospitals in the nine cities named below	

i. Option 2 excludes from Max Bupa's Cashless facility Covering Network Providers, located in the following cities and their sub-urban areas; Delhi/NCR, Mumbai (inc. Thane City and Navi Mumbai), Bengaluru, Chennai, Surat, Pune, Hyderabad, Kolkata and Ahmedabad.

ii. Choosing Option 2 would attract a 10% discount for your premium calculation

iii. If Option 2 is chosen all claims for treatment at hospitals located in nine cities named in point i. above, will be settled on re-imbursements basis only and a 20% Co-payment will apply for all such claims.

3. Top-up Option - You can choose a deductible on annual aggregate basis as per your choice.

Deductible Amount : ☐ 1Lac ☐ 2Lac ☐ 3Lac ☐ 4Lac ☐ 5Lac ☐ 10Lac

General Information: Section III

1. Family Physician Details: (Please fill in the following)

Family Physician's Name

Address

Contact No. **City**

District **State** **Pin Code**

2 .Checklist of Documents

a. ID Proof ☐ Passport ☐ Pan Card ☐ Voter ID ☐ Driving License ☐ Letter from Recognized Public Authority ☐ Others

b. Age Proof ☐ School/College Leaving Certificate ☐ Passport ☐ PAN Card ☐ Voter ID ☐ Driving License ☐ Letter from Recognized Public Authority ☐ Others

c. Address ☐ Passport ☐ Ration Card ☐ Voter ID ☐ Driving License ☐ Letter from Recognized Public Authority ☐ Utility (Electricity/Telephone) Bill ☐ Others

3. Existing Insurance Details

Is the proposer or any of the persons proposed to be insured already insured under or proposed for a health insurance policy for inpatient Care hospitalization and/or hospital cash with Max Bupa Health Insurance Company Limited or any other insurance company. If yes, please indicate below the policy/application number(s). (Please mention application number in case of pending proposal)

Since when have you been continuously insured D D M M Y Y Y Y

Name	Policy/Application No.	Insurer Name	From (date)	To (date)	Sum Insured	Claim details (if any)

In addition to the information given above, please also submit to Us (as an annexure to this proposal form) all the policy documents relating to the existing policy in order to avail of the potability be benefit from your existing insurance policy

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

- ☐ I/We 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/We am/are 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- ☐ I/We further declare that I/We 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/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- ☐ I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Government and/or Regulatory authority.

Authorization for electronic policy fulfillment and service communications

- ☐ I hereby consent that the policy documents may be sent to me by email at _____(Please provide us your e-mail id)
- ☐ I hereby consent to and authorize Max Bupa Health Insurance Company Limited (" Company") to make welcome calls, service calls or anyother communication (electronic or otherwise) with respect to the proposer or existing policy of Company from time to time.

Dated D D M M Y Y Y Y

Signature of the proposer _____

Place _____

Name of proposer _____

5. Vernacular Declaration

I hereby declare that I have fully explained the content of the proposal form and all other documents incidental to availing the health insurance from Max Bupa Health Insurance Company Limited to the proposer in the language understood by him/her. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the proposer and the replies have been read out to fully understood and confirmed by the proposer.

Declarant' s Name

Relationship with proposer

Address:

City Pin Code

Signature of declarant: _____ Signature of applicant in vernacular _____

Acknowledgment

Proposal Form No. Date D D M M Y Y Y Y

We acknowledge with thanks the receipt of your proposal and amount by cash/Cheque/Demand Draft/other _____of amount of Rs. _____dated_____ drawn on _____

Neither the submission to us of completed proposal for Insurance nor any payment for 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, if any, received from you without interest.

Signature of the receiver and office seal

For Office Use Only

Premium Payment Details: ☐ Cash ☐ Cheque/DD No. ☐ Credit Card

☐ Online Payment Transaction ID

Amount Date DD MM YYYY

Bank Name/Branch

Max Bupa Branch Location Code No.

Business Sourced By: Advisor/DST/Corporate Agency/Other Channels Code No.

Name Code No.

Proposal Received On: Date DD MM YYYY

Processed by ______________ Date DD MM YYYY Approved By ______________ Date DD MM YYYY

Customer ID

Additional Details for Bancassurance Channel only

Branch Code SP Code RM/LG Code

Customer Account No

Insurance Advisor's Report

1. Name of the proposer
2. Are you related to the proposer? ☐ Yes ☐ No
3. If yes, nature of relationship?
4. Is this a proposal form for yourself? ☐ Yes ☐ No
5. Since when do you know the Proposer? Years Months
6. Are you satisfied with the identity of the Proposer? ☐ Yes ☐ No
7. Does the Proposer have any physical deformity/defect or mental retardation? ☐ Yes ☐ No
8. Have you explained the exclusions of the policy and has the proposer personally completed the health declaration? ☐ Yes ☐ No
9. What is the Proposer's state of health at the time of making of this proposal form?
10. Do you recommend acceptance of this proposal form considering all the factors, including moral hazard? ☐ Yes ☐ No

Date : DD MM YYYY

Signature of the Insurance Advisor

STATUTORY WARRING AS PER SECTION 41 OF THE INSURANCE ACT 1938PROHIBITION OF REBATES

Payment of rebates is expressly prohibited 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 or risk relating to lives 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 continuing a policy accept any rebate except such rebate as may be allowed in accordance with the 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.

Max Bupa Health Insurance Company Limited
Corporate Office: Block B1/1-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi - 110044, Tel.: + 91-11-30902000
Registered Office: Max House, 1, Dr. Jha Marg, Okhla, New Delhi - 110020
www.maxbupa.com
CIN: U66000DL2008PLC182918, IRDA Registration No. 145

This page is not a part of the proposal form. In case you want to take the option of paying renewal premium through ECS, then you are requested to fill up this ECS form.

Renewal Payment Sign-up

Payment of renewal premium of your health insurance policy can be made every year through continuing your existing ECS instructions with Us. 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 Max Bupa. Would you like to opt for the ECS renewal option at this stage? ☐ Yes ☐ No

If you have chosen 'Yes above please fill up the ECS Mandate form attached along with this form.

Standing Instruction Mandate

Electronic Clearing Scheme/Direct Debit/Credit Card

UI Code _____ Mandate Reference No ☐☐☐☐☐☐☐☐☐☐ Customer ID ☐☐☐☐☐☐☐☐☐☐

Tick the applicable payment option to pay your renewal insurance premium

☐ Electronic Clearing Service (ECS)/Direct Debit ☐ Credit Card

Mandatory fields

Policy holder's Name*

Application Number (New)*

Policy Number (Renewals)*

Permanent Account Number* Email Id* _____

Mobile Number 1* Mobile Number 2

Landline Number with STD code Amount (in figures)

Premium Due Date Payment Frequency: Annual

ECS End Date

Information to be filled if the chosen option is Electronic Clearing Scheme and Direct Debit

☐ Yes, I have attached an original cancelled cheque/copy of the cheque for ECS/Direct Debit

Account Holder's Name*

Account Number*

Account Type ☐ Saving ☐ Current ☐ Cash Credit

Name and Address of the Bank/Branch*

9 Digit MICR Code* IFSC Code*

Information to be filled if the chosen option is Credit Card

☐ Yes, I have attached a copy of the front side of the Credit Card ☐ Master ☐ Visa ☐ Amex ☐ Diners

Credit Card Holder's Name*

Credit Card Name* Credit Card Expiry Date*

Name of the Issuing Bank*

Declaration by the Policy holder/Proposer/Account Holder

1.I/We hereby declare that the particulars given above are correct and complete in all respects. I/We acknowledge that I/We have read, understood and agree to be bound by the Terms and detailed in this standing Instruction mandate.

2.I/We authorize Max Bupa Health Insurance Company Limited ("the Insurer") its authorised service provider carrying this ECS (Debit Clearing) Mandate, to get it verified and executed and to collect the amounts as may be due on account of payment of health insurance premium payable on renewal of the policy as issued by the Insurer, by Debit to my Bank Account/Credit Card as per details provided above.

3.I/we authorize my/our bank/Credit Card to debit my account for charges towards mandate verification and transaction bounced due to "insufficient funds" as applicable. If the transaction is delayed or not effected at all for reasons of incomplete or incorrect information, I/We would not hold the Insurer responsible.

4.I/We will inform the Insurer of any changes in my/our Bank Account or Credit Card details. I/we agree for debit of premium amount up to 5 days earlier than the premium due date.

Name of the Issuing Bank*

Account Holder's Signature

Date ☐☐ ☐☐ ☐☐☐☐

Second Signature in case of Joint Holder

Place _____

Certificate of the bank named in the mandate (For Electronic Clearing Scheme and Direct Debit only)

It is certified that the particulars of the mandate above are correct and the signatures of the Bank Holder, are true as per our records and that a copy of this form duly completed has been submitted to us.

Signature of Authorised official of the Bank

Date ☐☐ ☐☐ ☐☐☐☐

Bank's Stamp

Place _____

Terms and Conditions

This Standing Instruction Mandate ("Mandate") offered by the Insurer governed by the following terms and conditions:

1. By opting for this facility. the Policy holder elects to make to the payment of renewal premiums to the Insurer from the Policy holder's Bank Account/credit Card through the payment utility site/aggregator that Insurer may tie up with from time to time.

2. The Policy holder agrees that the facilities will be available to him/her, subject to and upon receipt of confirmation by the Insurer and/or itsauthorised service provider from the Policy holder's bank of the details furnished by him/her in this Mandate.

3. The Insurer reserves the right to seek from the Policy holder such documents as may be deemed necessary for providing this facility including but not mandate verified from the bank.

4. The Insurer/its authorised service provider shall in no way be responsible for any damages/compensation for any loss, damages etc incurred by the policy holder (i) of use, non availability or deficiency in the provisioning of the facility: or (ii) Non-execution or delay in execution of this mandate either on account of incomplete or inaccurate information or non-availablity of sufficient funds in the account or for other reasons beyond the Insurer's control. The holder shall bear the entire responsibility for and risk associated with use of this facility.

5. The Policy holder will indemnify and hold the insurer/its authorised service provider harmless against any and all liability, costs and expenses arising out of any acts of ommission or commission or negligence on the part the proposer/policy holder/ account holder.

6. The insurer is to enable the ECS/Direct Debit/Credit Card facility for the premium payments and in the instance of instance of ECS/Direct Debit/Credit Card dishonour, to re-debit the policy Holder/Account with the mentioned bank to recover the premium due.

7. Renewal premium amount to be debited from the Policy holder's account may vary due to change in age. address and any other factors affecting the premium, other factors like change in plan, counter offers and change in tax structure.

8. The Policy holder agrees that the premium payment notice may not be the amount will be debited to the account.

9. The instructions under this mandate shall remain valid till revoked by the Policy holder by providing 30 days prior written notice.

10. Not withstanding what is mentioned herein above, it is understood and agreed that this facility is for the convenience of the Policy holder in making renewal premium payments. however the onus and liability to make such payments within the due dates specified in the relevant policy contracts(s) vests solely and absolutely with the Policy holder.

11. The Policy holder agrees that it shall be his/her sole responsibility to schedule his/her renewal premium payments in a manner that the Insurer receives the renewal premiums within the due dates as dates as specified in the relevant Policy contract(s) and that in the event of a late payment he/she shall be liable for the late payment charges and other consequences including losing continuity benefits as may be applicable and/or as enforced by the Insurer.

Instructions for filling up the Form

1. This form is to filled by the policy holder/account holder himself/herself in BLOCK LETTERS in Black or Blue ink.
2. Please tick a box ☑ where appropriate.
3. Please strike out parts. which are not applicable and write 'N.A' strokes of the pen. dots and dashes will not be accepted as input.
4. The Proposer must sign any cancellation or alteration.
5. Fields marked with asterisk (*) are mandatory
6. Premium due date is the Policy expiry date.
7. ECS End Date should be five years from the premium due date.
8. In case of any query, please write to ecsmandate@maxbupa.com

Key Feature Document

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

2 Year Specific waiting period: The 17 listed conditions (such as cataract, Hernia/Hydrocele, Knee/Hip Joint replacement, varicose veins, etc.) will be subject to a waiting period of 24 months from the date of inception of the coverage 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.

Renewal Benefit:
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.

Refill Benefit: Refill benefit is available only under Individual and Family Floater Plans. Family First plan does not have Refill benefit.

Tiered Network: Zone 1- (Delhi (NCR), Mumbai including Suburbs, Chennai, Bengaluru, Hyderabad, Kolkata, Pune, Ahmedabad, Surat. Zone 2 - other than zone 1.
If the customer has opted for claim settlement for Zone 2 and he/she is availing treatment in Zone 1 hospitals then treatment will be done on reimbursement basis only with the 20% co-payment.

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 75,000 then we will settle your claim only upto Rs.25,000 as your total claim exceeding Rs.1 lakh in the same policy year is Rs.25,000

Maternity Benefit is not available under this plan.

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: Variant 1 customers would be required to pay 50% of the PPMC cost at the Diagnostic Centre if a medical test is required .If the policy gets rejected basis the medical tests, balance 50% of the cost of PPMC shall be deducted from the premium while refunding it.

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.

Date: _____ Signature of Proposer _____

Place: _____ Name of Proposer _____