# NARAYANA ADITI PROPOSAL FORM

Version 3.0

Narayana Health Insurance

## BASE COVERS (SELECT FROM BELOW OPTIONS)

**Plan Option:** ☐ Plan 1 ☐ Plan 2

**Policy Tenure:** ☐ 1 Year ☐ 2 Years ☐ 3 Years

**Sum Insured Type:** ☐ Individual ☐ Family Floater

**Portability:** ☐ Yes ☐ No
(If yes, portability form to be completed and attached)

**Migration:** ☐ Yes ☐ No
(If yes, migration form to be completed and attached)

## OPTIONAL COVERS (SELECT FROM BELOW OPTIONS)

**Room Category Modification Options:** ☐ General Ward to Semi-Private Room ☐ General Ward to Private Room

**Deferred Initial Health check-up:** ☐ **Yes** *(Medical and Lifestyle Information and Declaration at pre Policy Issuance with Health Check-Up / Examination post Policy Issuance)* ☐ **No** *(Health Check-Up exists in Advance or Health Check-Up/Examination to be done before Policy Issuance)*

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

Complete details of each person to be covered should be furnished.

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

## PROPOSER'S DETAILS

***ABHA ID (If available)***

***Name of the Proposer (As per the Id Card)*** ***Date of Birth:*** D D M M Y Y Y Y

***Gender (M/F/T)*** M ***Male*** F ***Female*** T ***Transgender*** ***Nationality:***

***Residential Address (Permanent)***
LANDMARK AREA CITY TOWN
DISTRICT STATE PINCODE

***Address for Correspondence***
LANDMARK AREA CITY TOWN
DISTRICT STATE PINCODE

***Email Id*** ***Occupation***

***Landline/ Mobile Number*** ***Family Income***

***Nature of Id*** PANCARD / VOTER ID / ANY OTHER

***PAN Card No.*** ***Aadhaar No.*** X X X X X X X X X X X X

***Form 60 (Only incase a customer doesn't have PAN No.)*** ***Yes*** ☐ ***No*** ☐ ***GST No. (If applicable)***

***CKYC Number:*** ***Do you wish to update CKYC with the KYC details provided here*** ***Yes*** ☐ ***No*** ☐

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***Are you (Proposer) or any of the insured person is a PEP (Politically Exposed Person) or related to PEP*** ***Yes*** ☐ ***No*** ☐

***If yes, please provide details***

_____

_____

## Please share the following for authentication purpose:

### *Proof of Indentity (POI)* *(☐ Tick whichever is applicable)*

***PAN*** ☐ ***Aadhaar*** ☐ ***Passport*** ☐ ***Driving License*** ☐ ***Voter ID Card*** ☐

***Letter from a recognized public authority or public servant verifying the identity and residence of the Proposer*** ☐

### *Proof of Address (POA)* *(☐ Tick whichever is applicable)*

***Electricity bill (not older than 3 months)*** ☐ ***Aadhaar*** ☐ ***Passport*** ☐ ***Ration Card*** ☐

***Telephone Bill (not older than 3 months)*** ☐ ***Bank Account Statement (not older than 3 months)*** ☐

***Letter from a recognized public authority or public servant verifying the identity and residence of the Proposer*** ☐

***Would you like to opt for Electronic Policy Issuance through an e-Insurance Account (eIA) of an Insurance Repository*** ☐ ***Yes*** ☐ ***No***

***If you have an eIA, please provide following details:***

***i) Name of Insurance Repository:*** _____

***ii) eIA No:*** _____

***iii) Name as appearing in eIA:*** _____

***If you do not have an eIA, would you like to open an account?*** ☐ ***Yes*** ☐ ***No***

☐ ***NDML - NSDL Data Management Limited***

☐ ***CAMSRep - CAMS Limited Repository Services Limited***

☐ ***Karvy Insurance Repository Limited***

☐ ***CIRL - Central Insurance Repository Limited (CDSL)***

***Rural :*** ☐ ***Yes*** ☐ ***No***

***Social Sector :*** ☐ ***Yes*** ☐ ***No*** *If yes, please provide a copy of the document issued by the Government Authorities, in this regard.*

***Social Sub Category :*** _____

**Bank account details of the Proposer:**

**Name (as per bank records):** _____

**Account No.** _____ **Bank name:** _____

**IFSC code:** _____

*The above shall be used for purposes as may be defined by IRDAI.*

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## NOMINEE DETAILS

| S. No. | Particulars | Nominee 1 | Nominee 2 | Nominee 3 |
|---|---|---|---|---|
| 1 | Name | | | |
| 2 | Age | | | |
| 3 | Mobile No. | | | |
| 4 | Email ID | | | |
| 5 | Present Address | | | |
| 6 | Permanent Address | | | |
| 7 | Relationship with Proposer | | | |
| 8 | Specify the percentage (%) of the claim amount payable to each nominee in the event of the policyholder's death. The total percentage of contribution across all the nominee must not exceed 100% | | | |
| 9 | Bank Details of Nominee<br>Account no.<br>IFSC/MICR Code<br>Name of Bank<br>Account Holder Name | | | |
| 10 | Appointee Details<br>(Required only if nominee is a minor)<br>Name<br>Age#<br>Relationship with Nominee | | | |

**In the event of the death of the Proposer, any payment due under the Policy shall become payable to the Nominee proposed in this Proposal Form, as per the 'Nomination' clause defined by the IRDAI. The receipt of the proceeds by such Nominee would be sufficient and constitute discharge of the Company's liability. The Nominee for all the other person(s) proposed to be insured shall be the Proposer himself.**

# NARAYANA ADITI PROPOSAL FORM

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Narayana Health Insurance

## DETAILS OF THE PERSON(S) TO BE INSURED

### Adult 1

| Name: | Gender: | DOB: |
|---|---|---|
| Relationship with the primary proposer: | | |
| ABHA No. (if available): | If PEP: (YES / NO): | |

### Adult 2

| Name: | Gender: | DOB: |
|---|---|---|
| Relationship with the primary proposer: | | |
| ABHA No. (if available): | If PEP: (YES / NO): | |

### Child 1

| Name: | Gender: | DOB: |
|---|---|---|
| Relationship with the primary proposer: | | |
| ABHA No. (if available): | If PEP: (YES / NO): | |

### Child 2

| Name: | Gender: | DOB: |
|---|---|---|
| Relationship with the primary proposer: | | |
| ABHA No. (if available): | If PEP: (YES / NO): | |

### Child 3

| Name: | Gender: | DOB: |
|---|---|---|
| Relationship with the primary proposer: | | |
| ABHA No. (if available): | If PEP: (YES / NO): | |

### Child 4

| Name: | Gender: | DOB: |
|---|---|---|
| Relationship with the primary proposer: | | |
| ABHA No. (if available): | If PEP: (YES / NO): | |

# NARAYANA ADITI PROPOSAL FORM

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Narayana Health Insurance

## MEDICAL AND LIFESTYLE INFORMATION

*This section shall only be filled if "Deferred Initial Health check-up" is opted as "YES"*

*(PLEASE PROVIDE INFORMATION IN THE SAME ORDER AS MENTIONED UNDER PROPOSED PERSONS TO BE INSURED)*

## MEDICAL & LIFESTYLE QUESTIONS FOR PERSON PROPOSED TO BE INSURED

*[TO BE REPEATED FOR EACH PERSON PROPOSED TO BE INSURED]*

### NAME OF ADULT 1:

**Please select Medical Question for:**

| | | |
|---|---|---|
| 1. Has an ailment or disability or deformity including due to accident or congenital disease | ☐ Yes | ☐ No |
| 2. Has planned a surgery | ☐ Yes | ☐ No |
| 3. Takes medicines regularly | ☐ Yes | ☐ No |
| 4. Has been advised investigation or further tests | ☐ Yes | ☐ No |
| 5. Was hospitalized in the past | ☐ Yes | ☐ No |
| 6. Is Pregnant | ☐ Yes | ☐ No |
| 7. Are you having any disability/ deformity including accidental or congenital? | ☐ Yes | ☐ No |

### ADDITIONAL MEDICAL QUESTIONS

***[RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]***

1. Has an ailment or disability or deformity ☐ Yes ☐ No

If Yes, please provide the below details. Please tick additional information about your ailment for

- ☐ Hypertension/ High blood pressure
- ☐ Diabetes/ High blood sugar/Sugar in urine
- ☐ Cancer, Tumour, Growth or Cyst of any kind
- ☐ Chest Pain/ Heart Attack or any other Heart Disease/ Problem
- ☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
- ☐ Kidney ailment or Diseases of Reproductive organs
- ☐ Tuberculosis/ Asthma or any other Lung disorder
- ☐ Ulcer (Stomach/ Duodenal), or any ailment of Digestive System
- ☐ Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Nervous, Psychiatric or Mental or Sleep disorder
- ☐ Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage
- ☐ Any other disease/condition not mentioned above. Please provide details if this is ticked:

_____

_____

# NARAYANA ADITI PROPOSAL FORM

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Narayana Health Insurance

**(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure**
**Exact Diagnosis:**

Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? ☐ Yes ☐ No

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ No (If answer is 'No', below question is mandatory)

Have you stopped medication on Doctor's advice? ☐ Yes ☐ No

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

Hospital Name: _____

**(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine**

Exact Diagnosis: ☐ Type 1 DM/IDDM ☐ Type 2 DM ☐ GDM (Gestational Diabetes)

Are you taking insulin? ☐ Yes ☐ No

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

Hospital Name: _____

**(iii) Please share details for your ailment (except for Diabetes and Hypertension)**

Exact Diagnosis:  Diagnosis Date: D D M M Y Y Y Y

Treatment type: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

Current status: ☐ Pending Treatment ☐ Ongoing Treatment ☐ Cured ☐ If others, please specify:

_____

_____

_____

Biopsy report: ☐ Malignant ☐ Non-Malignant ☐ Not Applicable

Consultation Date: D D M M Y Y Y Y

Hospital Name: _____

Please share details of your treatment:

_____

_____

_____

**2. Has planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details**

**Please share details of surgery** *<name of the surgery>*

Exact Diagnosis: _____

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

Hospital Name: _____

Proposed Surgery: _____

Please share details of your past surgery: *<name of the surgery>*

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**3. Takes medicines regularly** ☐ **Yes** ☐ **No. If Yes, please provide the below details**

**Please share details of your current medication:** *<name(s) of the current medication(s)>*

(i) If exact diagnosis is Hypertension then please provide details of the below questions

Exact Diagnosis:

Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? ☐ Yes ☐ No.

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

(ii) If exact diagnosis is Diabetes then please provide details of the below questions

Exact Diagnosis:

Takes insulin: ☐ Yes ☐ No.

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

(iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:

Exact Diagnosis:

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

Medicine Name: _____

Please share details of your treatment: *<name of the treatment>*

**4. Has been advised investigation or further tests** ☐ Yes ☐ No. **If Yes, please provide the below details**

**Please provide details about investigation suggested by your Doctor** *<name(s) of the investigation(s)>*

Date of test: D D M M Y Y Y Y  Type of test: _____

Findings of tests:

_____

_____

**Please share / upload the investigation tests results**

**5. Was hospitalized in past** ☐ Yes ☐ No. **If Yes, please provide the below details**

**Please share details for your past medical condition** *<name(s) of the medical condition(s)>*

Exact Diagnosis:

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

Hospital Name: _____

**Please share details of your past medical condition:** _____

**6. Is Pregnant** ☐ Yes ☐ No. **If Yes, please provide the below details**

**Please share your expected delivery date with us:** D D M M Y Y Y Y

**7. Are you having any disability/ deformity including accidental or congenital?** ☐ **Yes** ☐ **No.**

**If Yes, Kindly tick the specific boxes that are applicable:**

- ☐ Amputation
- ☐ Musculoskeletal / Locomotor
- ☐ Neurological / Cerebral Palsy
- ☐ Polio
- ☐ Spinal cord
- ☐ Stroke
- ☐ Visual / Hearing disability
- ☐ Others

Kindly provide a detailed description for all boxes ticked above:

_____

_____

## LIFESTYLE QUESTIONS

*[RELEVANT SECTION TO BE FILLED]*

| | | |
|---|---|---|
| ☐ | Cigarette(s) | Per Day_____Per Week_____Per Month_____ since past _____ years |
| ☐ | Bidi(s) | Per Day_____Per Week_____Per Month_____ since past _____ years |
| ☐ | Tobacco Pouches | Per Day_____Per Week_____Per Month_____ since past _____ years |
| ☐ | Gutka Pouches | Per Day_____Per Week_____Per Month_____ since past _____ years |
| ☐ | Alcohol (Quantity) | Per Day_____Per Week_____Per Month_____ since past _____ years |
| ☐ | Drugs_(Quantity) | Per Day_____Per Week_____Per Month_____ since past _____ years |

# NARAYANA ADITI PROPOSAL FORM

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## MEDICAL AND LIFESTYLE INFORMATION

*This section shall only be filled if "Deferred Initial Health check-up" is opted as "YES"*

*(PLEASE PROVIDE INFORMATION IN THE SAME ORDER AS MENTIONED UNDER PROPOSED PERSONS TO BE INSURED)*

## MEDICAL & LIFESTYLE QUESTIONS FOR PERSON (ADULT) PROPOSED TO BE INSURED

*[TO BE REPEATED FOR EACH ADULT PROPOSED TO BE INSURED]*

### NAME OF ADULT 2:

**Please select Medical Question for:**

| | | |
|---|---|---|
| 1. Has an ailment or disability or deformity including due to accident or congenital disease | ☐ Yes | ☐ No |
| 2. Has planned a surgery | ☐ Yes | ☐ No |
| 3. Takes medicines regularly | ☐ Yes | ☐ No |
| 4. Has been advised investigation or further tests | ☐ Yes | ☐ No |
| 5. Was hospitalized in the past | ☐ Yes | ☐ No |
| 6. Is Pregnant | ☐ Yes | ☐ No |
| 7. Are you having any disability/ deformity including accidental or congenital? | ☐ Yes | ☐ No |

### ADDITIONAL MEDICAL QUESTIONS

***[RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]***

1. Has an ailment or disability or deformity ☐ Yes ☐ No

If Yes, please provide the below details. Please tick additional information about your ailment for

- ☐ Hypertension/ High blood pressure
- ☐ Diabetes/ High blood sugar/Sugar in urine
- ☐ Cancer, Tumour, Growth or Cyst of any kind
- ☐ Chest Pain/ Heart Attack or any other Heart Disease/ Problem
- ☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
- ☐ Kidney ailment or Diseases of Reproductive organs
- ☐ Tuberculosis/ Asthma or any other Lung disorder
- ☐ Ulcer (Stomach/ Duodenal), or any ailment of Digestive System
- ☐ Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Nervous, Psychiatric or Mental or Sleep disorder
- ☐ Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage
- ☐ Any other disease/condition not mentioned above. Please provide details if this is ticked:

_____

_____

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**(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure**
**Exact Diagnosis:**

Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? ☐ Yes ☐ No

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ No (If answer is 'No', below question is mandatory)

Have you stopped medication on Doctor's advice? ☐ Yes ☐ No

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

Hospital Name: _____

**(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine**

Exact Diagnosis: ☐ Type 1 DM/IDDM ☐ Type 2 DM ☐ GDM (Gestational Diabetes)

Are you taking insulin? ☐ Yes ☐ No

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

Hospital Name: _____

**(iii) Please share details for your ailment (except for Diabetes and Hypertension)**

Exact Diagnosis:  Diagnosis Date: D D M M Y Y Y Y

Treatment type: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

Current status: ☐ Pending Treatment ☐ Ongoing Treatment ☐ Cured ☐ If others, please specify:

_____

_____

_____

Biopsy report: ☐ Malignant ☐ Non-Malignant ☐ Not Applicable

Consultation Date: D D M M Y Y Y Y

Hospital Name: _____

Please share details of your treatment:

_____

_____

_____

**2. Has planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details**

**Please share details of surgery** *<name of the surgery>*

Exact Diagnosis: _____

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

Hospital Name: _____

Proposed Surgery: _____

Please share details of your past surgery: *<name of the surgery>*

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**3. Takes medicines regularly** ☐ **Yes** ☐ **No. If Yes, please provide the below details**

**Please share details of your current medication:** *<name(s) of the current medication(s)>*

(i) If exact diagnosis is Hypertension then please provide details of the below questions

Exact Diagnosis:

Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? ☐ Yes ☐ No.

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

(ii) If exact diagnosis is Diabetes then please provide details of the below questions

Exact Diagnosis:

Takes insulin: ☐ Yes ☐ No.

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

(iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:

Exact Diagnosis:

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

Medicine Name: _____

Please share details of your treatment: *<name of the treatment>*

**4. Has been advised investigation or further tests** ☐ Yes ☐ No. **If Yes, please provide the below details**

**Please provide details about investigation suggested by your Doctor** *<name(s) of the investigation(s)>*

Date of test: D D M M Y Y Y Y  Type of test: _____

Findings of tests:

_____

_____

**Please share / upload the investigation tests results**

**5. Was hospitalized in past** ☐ Yes ☐ No. **If Yes, please provide the below details**

**Please share details for your past medical condition** *<name(s) of the medical condition(s)>*

Exact Diagnosis:

Diagnosis Date: D D M M Y Y Y Y  Consultation Date: D D M M Y Y Y Y

Hospital Name: _____

**Please share details of your past medical condition:** _____

**6. Is Pregnant** ☐ Yes ☐ No. **If Yes, please provide the below details**

**Please share your expected delivery date with us:** D D M M Y Y Y Y

**7. Are you having any disability/ deformity including accidental or congenital?** ☐ **Yes** ☐ **No.**

**If Yes, Kindly tick the specific boxes that are applicable:**

- ☐ Amputation
- ☐ Musculoskeletal / Locomotor
- ☐ Neurological / Cerebral Palsy
- ☐ Polio
- ☐ Spinal cord
- ☐ Stroke
- ☐ Visual / Hearing disability
- ☐ Others

Kindly provide a detailed description for all boxes ticked above:

_____

_____

## LIFESTYLE QUESTIONS

*[RELEVANT SECTION TO BE FILLED]*

| | | |
|---|---|---|
| ☐ | Cigarette(s) | Per Day_____Per Week_____Per Month_____ since past _____ years |
| ☐ | Bidi(s) | Per Day_____Per Week_____Per Month_____ since past _____ years |
| ☐ | Tobacco Pouches | Per Day_____Per Week_____Per Month_____ since past _____ years |
| ☐ | Gutka Pouches | Per Day_____Per Week_____Per Month_____ since past _____ years |
| ☐ | Alcohol (Quantity) | Per Day_____Per Week_____Per Month_____ since past _____ years |
| ☐ | Drugs_(Quantity) | Per Day_____Per Week_____Per Month_____ since past _____ years |

# NARAYANA ADITI PROPOSAL FORM

Version 3.0

Narayana Health Insurance

## MEDICAL AND LIFESTYLE INFORMATION

*This section shall only be filled if "Deferred Initial Health check-up" is opted as "YES"*

*(PLEASE PROVIDE INFORMATION IN THE SAME ORDER AS MENTIONED UNDER PROPOSED PERSONS TO BE INSURED)*

## MEDICAL & LIFESTYLE QUESTIONS FOR PERSON (CHILD) PROPOSED TO BE INSURED

*[TO BE REPEATED FOR EACH CHILD PROPOSED TO BE INSURED]*

## NAME OF CHILD 1:

## BASIC DETAILS

**Height: _____ cms**

**Weight: _____ kgs**

**Weight for height: _____ kgs (to be filled in by Underwriting Desk)**

## MEDICAL QUESTIONS

1. Does your child have any hereditary or genetic condition? ☐ Yes ☐ No

*(Please mention even if the condition is in carrier state i.e. did not have the disease but was a carrier). Eg: Color Blindness, Haemophilia, Birth defects, Rheumatoid Arthritis, Lupus, Muscular dystrophy, Thalassemia, Cleft lip, Cleft Palate.*

2. Is your child suffering from any disease or condition OR has ever been diagnosed with:

- ☐ Typhoid
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Diabetes
- ☐ Thyroid related Problems
- ☐ Any kind of cancer (Benign or malignant tumour), Growth or Cyst of any kind
- ☐ Leukaemia
- ☐ Heart condition/Palpitation
- ☐ Hypertension/ High blood pressure
- ☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
- ☐ Kidney ailment/disease
- ☐ Diseases of Reproductive organs
- ☐ Tuberculosis/ Asthma/Reactive Airway Disease or any other Lung disorder
- ☐ Any Blood disorder (example Anemia, Hemophilia, Thalassemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Developmental delay or disorder
- ☐ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture, or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage

- ☐ Hernia, Hydrocele, Any other disease/condition not mentioned above.
- ☐ Recurrent ear discharge, polyp, persistent sinusitis, hearing loss, nasal septum disorders, laryngitis/adenoiditis/tonsillitis
- ☐ Skin rashes, Psoriasis, leukoderma, eczema, dermatitis, erythema, vitiligo, etc.
- ☐ Any disease or problems of urinary tract (Urinary tract means Kidneys, Ureter and urinary bladder) Stones like Kidney stone, Gall bladder stone, Ureteric Stones, Stone in Urinary Bladder etc.

**For all ticked options, please provide details of the Disease(s):**

_____

_____

_____

_____

_____

_____

3. Has your child undergone any investigations other than for insurance purpose medicals in last 1 month?

☐ Yes ☐ No

If Yes, please provide details below:

_____

_____

_____

4. Is Your child under any follow up for past diseases or conditions, please mention if not mentioned already

☐ Yes ☐ No

If Yes, please provide details below:

_____

_____

_____

5. Does Your child take any medicine regularly or has taken medicine continuously for more than 15 days in the last 5 years, please mention, if not mentioned earlier.

☐ Yes ☐ No

If Yes, please provide details below:

_____

_____

_____

6. Is your child awaiting any treatment or surgery?

☐ Yes ☐ No

If Yes, please provide details below:

_____

_____

_____

7. Is there anything you would like to inform me about the health, medical history or lifestyle & habits of your child?

☐ Yes ☐ No

If Yes, please provide details below:

_____

_____

_____

8. Does your child have any disability/ deformity including accidental or congenital?

☐ Yes ☐ No

If Yes, kindly tick the specific boxes that are applicable and provide details in the space provided below:

- ☐ Congenital Heart Disease
- ☐ Musculoskeletal / Locomotor/Neurological / Cerebral Palsy
- ☐ Polio
- ☐ Spinal cord
- ☐ Autism / ADHD
- ☐ Visual / Hearing disability
- ☐ Others

_____

_____

_____

# NARAYANA ADITI PROPOSAL FORM

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## MEDICAL AND LIFESTYLE INFORMATION

*This section shall only be filled if "Deferred Initial Health check-up" is opted as "YES"*

*(PLEASE PROVIDE INFORMATION IN THE SAME ORDER AS MENTIONED UNDER PROPOSED PERSONS TO BE INSURED)*

## MEDICAL & LIFESTYLE QUESTIONS FOR PERSON (CHILD) PROPOSED TO BE INSURED

*[TO BE REPEATED FOR EACH CHILD PROPOSED TO BE INSURED]*

## NAME OF CHILD 2:

## BASIC DETAILS

**Height: _____ cms**

**Weight: _____ kgs**

**Weight for height: _____ kgs (to be filled in by Underwriting Desk)**

## MEDICAL QUESTIONS

1. Does your child have any hereditary or genetic condition? ☐ Yes ☐ No

*(Please mention even if the condition is in carrier state i.e. did not have the disease but was a carrier). Eg: Color Blindness, Haemophilia, Birth defects, Rheumatoid Arthritis, Lupus, Muscular dystrophy, Thalassemia, Cleft lip, Cleft Palate.*

2. Is your child suffering from any disease or condition OR has ever been diagnosed with:

- ☐ Typhoid
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Diabetes
- ☐ Thyroid related Problems
- ☐ Any kind of cancer (Benign or malignant tumour), Growth or Cyst of any kind
- ☐ Leukaemia
- ☐ Heart condition/Palpitation
- ☐ Hypertension/ High blood pressure
- ☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
- ☐ Kidney ailment/disease
- ☐ Diseases of Reproductive organs
- ☐ Tuberculosis/ Asthma/Reactive Airway Disease or any other Lung disorder
- ☐ Any Blood disorder (example Anemia, Hemophilia, Thalassemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Developmental delay or disorder
- ☐ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture, or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage

- ☐ Hernia, Hydrocele, Any other disease/condition not mentioned above.
- ☐ Recurrent ear discharge, polyp, persistent sinusitis, hearing loss, nasal septum disorders, laryngitis/adenoiditis/tonsillitis
- ☐ Skin rashes, Psoriasis, leukoderma, eczema, dermatitis, erythema, vitiligo, etc.
- ☐ Any disease or problems of urinary tract (Urinary tract means Kidneys, Ureter and urinary bladder) Stones like Kidney stone, Gall bladder stone, Ureteric Stones, Stone in Urinary Bladder etc.

**For all ticked options, please provide details of the Disease(s):**

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3. Has your child undergone any investigations other than for insurance purpose medicals in last 1 month?

☐ Yes ☐ No

If Yes, please provide details below:

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4. Is Your child under any follow up for past diseases or conditions, please mention if not mentioned already

☐ Yes ☐ No

If Yes, please provide details below:

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5. Does Your child take any medicine regularly or has taken medicine continuously for more than 15 days in the last 5 years, please mention, if not mentioned earlier.

☐ Yes ☐ No

If Yes, please provide details below:

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6. Is your child awaiting any treatment or surgery?

☐ Yes ☐ No

If Yes, please provide details below:

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7. Is there anything you would like to inform me about the health, medical history or lifestyle & habits of your child?

☐ Yes ☐ No

If Yes, please provide details below:

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8. Does your child have any disability/ deformity including accidental or congenital?

☐ Yes ☐ No

If Yes, kindly tick the specific boxes that are applicable and provide details in the space provided below:

- ☐ Congenital Heart Disease
- ☐ Musculoskeletal / Locomotor/Neurological / Cerebral Palsy
- ☐ Polio
- ☐ Spinal cord
- ☐ Autism / ADHD
- ☐ Visual / Hearing disability
- ☐ Others

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# NARAYANA ADITI PROPOSAL FORM

Version 3.0

Narayana Health Insurance

## MEDICAL AND LIFESTYLE INFORMATION

*This section shall only be filled if "Deferred Initial Health check-up" is opted as "YES"*

*(PLEASE PROVIDE INFORMATION IN THE SAME ORDER AS MENTIONED UNDER PROPOSED PERSONS TO BE INSURED)*

## MEDICAL & LIFESTYLE QUESTIONS FOR PERSON (CHILD) PROPOSED TO BE INSURED

*[TO BE REPEATED FOR EACH CHILD PROPOSED TO BE INSURED]*

## NAME OF CHILD 3:

## BASIC DETAILS

**Height: _____ cms**

**Weight: _____ kgs**

**Weight for height: _____ kgs (to be filled in by Underwriting Desk)**

## MEDICAL QUESTIONS

1. Does your child have any hereditary or genetic condition? ☐ Yes ☐ No

*(Please mention even if the condition is in carrier state i.e. did not have the disease but was a carrier). Eg: Color Blindness, Haemophilia, Birth defects, Rheumatoid Arthritis, Lupus, Muscular dystrophy, Thalassemia, Cleft lip, Cleft Palate.*

2. Is your child suffering from any disease or condition OR has ever been diagnosed with:

- ☐ Typhoid
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Diabetes
- ☐ Thyroid related Problems
- ☐ Any kind of cancer (Benign or malignant tumour), Growth or Cyst of any kind
- ☐ Leukaemia
- ☐ Heart condition/Palpitation
- ☐ Hypertension/ High blood pressure
- ☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
- ☐ Kidney ailment/disease
- ☐ Diseases of Reproductive organs
- ☐ Tuberculosis/ Asthma/Reactive Airway Disease or any other Lung disorder
- ☐ Any Blood disorder (example Anemia, Hemophilia, Thalassemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Developmental delay or disorder
- ☐ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture, or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage

- ☐ Hernia, Hydrocele, Any other disease/condition not mentioned above.
- ☐ Recurrent ear discharge, polyp, persistent sinusitis, hearing loss, nasal septum disorders, laryngitis/adenoiditis/tonsillitis
- ☐ Skin rashes, Psoriasis, leukoderma, eczema, dermatitis, erythema, vitiligo, etc.
- ☐ Any disease or problems of urinary tract (Urinary tract means Kidneys, Ureter and urinary bladder) Stones like Kidney stone, Gall bladder stone, Ureteric Stones, Stone in Urinary Bladder etc.

**For all ticked options, please provide details of the Disease(s):**

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3. Has your child undergone any investigations other than for insurance purpose medicals in last 1 month?

☐ Yes ☐ No

If Yes, please provide details below:

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4. Is Your child under any follow up for past diseases or conditions, please mention if not mentioned already

☐ Yes ☐ No

If Yes, please provide details below:

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5. Does Your child take any medicine regularly or has taken medicine continuously for more than 15 days in the last 5 years, please mention, if not mentioned earlier.

☐ Yes ☐ No

If Yes, please provide details below:

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6. Is your child awaiting any treatment or surgery?

☐ Yes ☐ No

If Yes, please provide details below:

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7. Is there anything you would like to inform me about the health, medical history or lifestyle & habits of your child?

☐ Yes ☐ No

If Yes, please provide details below:

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8. Does your child have any disability/ deformity including accidental or congenital?

☐ Yes ☐ No

If Yes, kindly tick the specific boxes that are applicable and provide details in the space provided below:

- ☐ Congenital Heart Disease
- ☐ Musculoskeletal / Locomotor/Neurological / Cerebral Palsy
- ☐ Polio
- ☐ Spinal cord
- ☐ Autism / ADHD
- ☐ Visual / Hearing disability
- ☐ Others

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# NARAYANA ADITI PROPOSAL FORM

Version 3.0

Narayana Health Insurance

## MEDICAL AND LIFESTYLE INFORMATION

*This section shall only be filled if "Deferred Initial Health check-up" is opted as "YES"*

*(PLEASE PROVIDE INFORMATION IN THE SAME ORDER AS MENTIONED UNDER PROPOSED PERSONS TO BE INSURED)*

## MEDICAL & LIFESTYLE QUESTIONS FOR PERSON (CHILD) PROPOSED TO BE INSURED

*[TO BE REPEATED FOR EACH CHILD PROPOSED TO BE INSURED]*

## NAME OF CHILD 4:

## BASIC DETAILS

**Height: _____ cms**

**Weight: _____ kgs**

**Weight for height: _____ kgs (to be filled in by Underwriting Desk)**

## MEDICAL QUESTIONS

1. Does your child have any hereditary or genetic condition? ☐ Yes ☐ No

*(Please mention even if the condition is in carrier state i.e. did not have the disease but was a carrier). Eg: Color Blindness, Haemophilia, Birth defects, Rheumatoid Arthritis, Lupus, Muscular dystrophy, Thalassemia, Cleft lip, Cleft Palate.*

2. Is your child suffering from any disease or condition OR has ever been diagnosed with:

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- ☐ Encephalitis
- ☐ Diabetes
- ☐ Thyroid related Problems
- ☐ Any kind of cancer (Benign or malignant tumour), Growth or Cyst of any kind
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- ☐ Heart condition/Palpitation
- ☐ Hypertension/ High blood pressure
- ☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
- ☐ Kidney ailment/disease
- ☐ Diseases of Reproductive organs
- ☐ Tuberculosis/ Asthma/Reactive Airway Disease or any other Lung disorder
- ☐ Any Blood disorder (example Anemia, Hemophilia, Thalassemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Developmental delay or disorder
- ☐ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture, or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage

- ☐ Hernia, Hydrocele, Any other disease/condition not mentioned above.
- ☐ Recurrent ear discharge, polyp, persistent sinusitis, hearing loss, nasal septum disorders, laryngitis/adenoiditis/tonsillitis
- ☐ Skin rashes, Psoriasis, leukoderma, eczema, dermatitis, erythema, vitiligo, etc.
- ☐ Any disease or problems of urinary tract (Urinary tract means Kidneys, Ureter and urinary bladder) Stones like Kidney stone, Gall bladder stone, Ureteric Stones, Stone in Urinary Bladder etc.

**For all ticked options, please provide details of the Disease(s):**

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3. Has your child undergone any investigations other than for insurance purpose medicals in last 1 month?

☐ Yes ☐ No

If Yes, please provide details below:

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4. Is Your child under any follow up for past diseases or conditions, please mention if not mentioned already

☐ Yes ☐ No

If Yes, please provide details below:

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5. Does Your child take any medicine regularly or has taken medicine continuously for more than 15 days in the last 5 years, please mention, if not mentioned earlier.

☐ Yes ☐ No

If Yes, please provide details below:

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6. Is your child awaiting any treatment or surgery?

☐ Yes ☐ No

If Yes, please provide details below:

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7. Is there anything you would like to inform me about the health, medical history or lifestyle & habits of your child?

☐ Yes ☐ No

If Yes, please provide details below:

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8. Does your child have any disability/ deformity including accidental or congenital?

☐ Yes ☐ No

If Yes, kindly tick the specific boxes that are applicable and provide details in the space provided below:

- ☐ Congenital Heart Disease
- ☐ Musculoskeletal / Locomotor/Neurological / Cerebral Palsy
- ☐ Polio
- ☐ Spinal cord
- ☐ Autism / ADHD
- ☐ Visual / Hearing disability
- ☐ Others

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# NARAYANA ADITI
# PROPOSAL FORM

Version 3.0

## IMPORTANT

a. The Proposal form shall be duly filled by the primary proposer and/if required by the dependents.

b. The information that you give to us on this proposal form or in any supplementary information form or documentation supplied by you or on your behalf will influence our decision to offer insurance and the terms upon which to offer it. Further, any policy we issue will be based on what you have communicated to us. It is therefore important that your the answer is complete and accurate in all respects.

c. The questions in this proposal are indicative rather than exhaustive. You must provide us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your Agent/Insurance Advisor/ Insurance Company, as the case maybe.

d. The list of exclusions/inclusions and other policy details are indicative, for the complete list and comprehensive details kindly refer to policy wordings.

e. The Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure of material particulars in the Proposal Form/personal statement, declaration and connected documents, or any material fact* information has been withheld by beneficiary or anyone acting on beneficiary's behalf to obtain insurance.

***A material fact will mean and include all important, essential and relevant information, pertaining to the questions made in this proposal form, that are likely to influence company's acceptance or assessment of the proposal.**

## PROPOSER DECLARATION:

### I declare that the persons proposed for insurance are my family members and:

a. 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.

b. I/We 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 company and that the policy will come into force only after full receipt of the premium chargeable, which is subject to change basis underwriting outcomes.

c. 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.

d. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time 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.

e. I/We authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority(ies), including seeking and / or sharing of my medical data through ABHA.

f. I/We accept to undertake any required medical assessment or/and examination at the allocated center and shall provide correct responses, wherever sought. This is an integral part of the proposal form and I/We understand that this is a prerequisite for all the persons to be Insured to undergo any requested medical examination post which the status of the proposal form shall be treated as completed for further processing. However, the company may accept health check-up reports from empaneled clinics or hospitals, either partially ot fully, if they were issued within six months prior to the date of the proposal.

g. I/We hereby confirm that the features of the product have been understood by me and that the payment after the underwriting decision will be made through my card/bank account/UPI. By making this payment, I/ We also confirm that I/ we have fully understand all Terms & Conditions applicable for the issuance of Policy to me/us. Additionally, I/We confirm that the source of funds for the premium paid under this policy shall be legal.

h. I/We hereby authorize Narayana Health Insurance Limited, its group companies (including its holding, subsidiaries, affiliates, etc.), and any of its authorized service providers to contact me via telephone, WhatsApp, or email at the contact details provided in my name. This authorization will override any registration of my telephone number under the National Do Not Call/Do Not Disturb Registry on the NCPR. Additionally, I/We authorize Narayana Health Insurance Limited to share my recent health check findings with the medical professionals at Narayana Hrudayalaya Limited. These findings, which include all relevant medical tests, reports, and assessments conducted during my health check, will be used solely for medical recommendations and treatment. I/We acknowledge that sharing this information is necessary to provide accurate and effective medical care during my treatment or any associated procedures at the hospital, and I/We consent to this disclosure voluntarily.

i. I/We would like to contribute to creating a healthier, greener and cleaner environment by authorising the company to send all my policy & service-related communication to the Email ID / WhatsApp / SMS over registered mobile number mentioned in this application form.

j. I/We have read, understood and agreed to the Privacy Notice provided in the website - www.narayanahealth.insurance.

k. I/We declare that I/We have read the entire proposal form and terms and conditions or/ and that any unfamiliar language or contents have been fully explained (also in vernacular language, if needed) to me/us by the Agent, Corporate Agent, Broker, Insurer, Group Master Policyholder as the case may be.

l. I/We declare that I/we have not been considered ineligible for any health insurance product by Narayana Health Insurance in the past, excluding the deferred cases for which I/We have been offered to re-apply after a certain period of time as specified.

**Place:** _____

**Signature of Proposer:** _____ **Date:** _____/_____/_____

## STATUTORY WARNING

**Section 41 of the Insurance Act, 1938 (Prohibition of Rebates)** 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 insurance in respect or 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 in the policy, nor shall any person taking out of renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or table of the Insurer. Any person making a default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

## AGENT DECLARATION

I,_____, in my capacity as an Agent/ Insurance Advisor/ Specified Person of the Corporate Agent/ Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy.

I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to cancel the policy at its discretion. Further, this declaration does not confirm issuance of policy or assumption of risk thereof.

Name: _____ Date: _____ Place: _____

License No. (Advisor / Corporate Agent / Broker / Insurer / Relationship officer):

_____ Signature : _____

# NARAYANA ADITI
# PROPOSAL FORM
Version 3.0

## DECLARATION BY AUTHORIZED REPRESENTATIVE (INCL. FOR PERSON(S) WITH DISABILITY)

**I _____ Son/Daughter of _____, resident of _____ declare that I have read out and fully explained the contents of the Proposal Form and all other accompanying documents in _____ language to the Proposer which is a language understood by him/her and is imperative for the Proposer to avail the insurance from the Company. The contents and import of the proposal have been fully understood by him/her and the replies have been recorded according to the information provided by the Proposer. the replies have also been read out to, fully understood and confirmed by the Proposer:**

**License No. (Advisor / Corporate Agent / Broker / Insurer):**

**Date: _____/_____/_____ (DD/MM/YYYY)**

**Place: _____**

**Name of the Declarant: _____**

**Signature of the Declarant: _____**

**(On behalf of all the Proposed to be Insured under the Policy)**

# NARAYANA ADITI PROPOSAL FORM

Version 3.0

## ACKNOWLEDGEMENT FOR THE PROPOSAL

**Please retain this counter foil for your records**

**(On behalf of Narayana Health Insurance Limited)**

**Proposal No:** _____

**Please note that this is only an acknowledgement receipt for completion of details in this form and does not amount to acceptance of risk or commencement of policy. The commencement of policy shall happen once the full Premium has been received post underwriting decision and issuance of the policy document.**

**Acceptance of proposal and insurance of the Policy shall be subject to receipt of the completed Proposal Form which includes medical assessment or/and examination of all the persons to be Insured seeking the policy, premium payment, medical reports (wherever applicable) and underwriting by the insurance company.**

**Signature of the representative:** _____ **Name of the Representative:** _____

**IRDAI Registration No. 166**