	UNITED INDIA INSURANCE COMPANY LIMITED **Divisional Office No. XIX, Savitri Chambers II,** **D-13, Local shopping complex Prashant Vihar Delhi-11008**	**Agency Code 912**

PROPOSAL FORM FOR REVISED MEDICLAIM INSURANCE POLICY
PROPOSER DETAILS

Name & address of Proposer	…….. …….. ……..	Photo	Photo	Photo	Photo
1. Name of the Insured Person :					
2. Residential address : State / U. Territory					
3. Sex		M /F	M /F	M /F	M /F
4. Relationship with the Proposer. 5. Date of Birth and age.					
6. (a) Average monthly Income Rs. : (b) Income Tax Pan No.					
7. Profession / Occupation / Trade or					
8. Name and address of the Medical Practitioner, his qualifications & Telephone No. if any:					
9. Medical Practitioner s Regn. No.					
10. Are you at present or any other time In the past covered under any other Insurance Type (PA, Cancer Insurance, hospitalisation Insurance or other Medical Insurance), if so, Give particulars of (a) Insurer, Policy No. and period of cover From to (b) Claim Amount Received / Receivable					
11. Any proposal for this Insurance or Any other similar Insurance refused Or higher premium charged if so give Details					
12. MEDICAL HISTORY TO BE COMPLETED BY THE PROPOSER / INSURED PERSON					
(a) Are you in good health and free from Physical and mental disease or infirmity Or medical Complaints?		Yes/No	Yes/No	Yes/No	Yes/No
(b) If not in good health give full details:		Yes/No	Yes/No	Yes/No	Yes/No
13. Have you ever suffered from any of the Disease / illness? if yes, give details		Yes/No	Yes/No	Yes/No	Yes/No
(a) Any nervous, mental or psychiatric disease.		Yes/No	Yes/No	Yes/No	Yes/No
(b) Slipped disc or other spinal disorder or (fainting episode, blackout, fit) paralysis of any kind.		Yes/No	Yes/No	Yes/No	Yes/No
(c) High blood pressure, heart disease, including Ischaemic heart disease, other circulatory Disorders etc. (rheumatic fever)		Yes/No	Yes/No	Yes/No	Yes/No
(d) Fistula, Piles, Hernia, Varicose veins.		Yes/No	Yes/No	Yes/No	Yes/No
(e) Any disease of the bones or joints including Rheumatic disease.		Yes/No	Yes/No	Yes/No	Yes/No
(f) Disease of uterus, ovaries or breast or any Specific gynecological disorders		Yes/No	Yes/No	Yes/No	Yes/No
(g) Any respiratory or allergic disease.		Yes/No	Yes/No	Yes/No	Yes/No
(h) Any disorder of the stomach, ulcer, bowel or Gall bladder, kidney stones etc.		Yes/No	Yes/No	Yes/No	Yes/No
(i) Any cancer, malignant growth, boil, cyst or Wound etc. which does not heal or improve Despite treatment.		Yes/No	Yes/No	Yes/No	Yes/No
(j) Any other complaint requiring specialist's Consultation or surgical or hospital treatment or investigations		Yes/No	Yes/No	Yes/No	Yes/No
(k) Any complaint or tendency that may necessitate such consultation or Treatment in the future		Yes/No	Yes/No	Yes/No	Yes/No
(l) Any dimness of vision / cataract		Yes/No	Yes/No	Yes/No	Yes/No
(m) Any disease of ears or difficulty or Interference with hearing		Yes/No	Yes/No	Yes/No	Yes/No
(n) Diabetes or any urinary disease		Yes/No	Yes/No	Yes/No	Yes/No
(o) Any other illness or disease or accident Or operation sustained by you		Yes/No	Yes/No	Yes/No	Yes/No
14. (a) Have you ever suffered from dental Problems ? Yes/No (b) if yes, specify same (c) When were you treated last for same		Yes/No	Yes/No	Yes/No	Yes/No

Signature of Insured

15. Give particulars in table below of any other illness or disease or accident or operation sustained by you in the past.

Name of the person	Name if illness / disease injury & Date first treated	Name of attending medical practitioner surgeon with his address and Telephone No	And treatment received	Whether fully cured
1 2 3.				

16. Are there any additional facts affecting the proposed Insurance Which should be disclosed to Insurers?				
17. Please give details of any knowledge of any positive existence or presence of any ailment / sickness or injury which may require medical attention 1. 2. 3. 4.				
18. Please specify Sum Insured option Rs.				

I hereby declare and warrant that the above statements are true and complete. I consent and authorize the Insurers to seek medical information from any Hospital / Medical Practitioner who has at any time attended or may attend concerning any disease or illness which affects my physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be effected. If after the insurance is affected, it is found that the statements answers or particulars stated in the proposal form and its questionnaire is incorrect or untrue in any respect, the Insurance Company shall incur no liability under this Insurance. I have read the Prospectus and I/am willing to accept the coverage subject to terms, conditions and exceptions prescribed by the Insurance Company therein.

Signature: Date Place

TO BE COMPLETED BY PROPOSER IN CASE OF ADVERSE HISTORY IN THE PROPOSAL FORM IN RESPECT OF APPLICABLE ILLNESS

DIABETES QUESTIONNAIRE

1. Date of diagnosis of Diabetes:				
2. Did you suffer from coma or procoma?				
3. Do you take any antidiabetic drugs? If so, please give name with dose.				
4. Please give details of Fasting and Postprandial Blood Sugar readings, E.C.G. Findings and other investigation reports With dates, please also send reports.				
5. Do you suffer or have suffered from any Complications of diabetes or any other Disease?				

HYPERTENSION QUESTIONNAIRE

1. What your Blood pressure reading? Please state with dates?				
2. Please state names of antithypertensive Drugs with dose?				
3. Are you a smoker?				
4. Is it Essential /Secondary/Malignant Hypertension?				
5. Please state whether you have suffered from any complications or other diseases?				
6. Please give findings of all investigation Reports?				

CHEST PAIN OR CORONARY INSUFFICIENCY OR MYOCARDIAL INFARCTION QESTIONNAIRE

1. Did you ever suffer from chest pain or Coronary insufficiency or myocardial Infarction? If so, please give diagnosis And date				
2. Please state the name and dose of drugs You are taking at present				
3. Please state the findings with dates of Investigations done like ECG, Stress test, Coronary angiography, X-ray, Pathology Reports etc. Please send reports with the Proposal form.				
4. Please state the date of hospitalisation and Names of hospitals and consultants.				
5. Please state complications and other disease, If suffered.				
6. Please state whether you can do your regular Work and whether you have any limitation of Activity.				
7. Are you advised any special treatment? If so, please give information.				

(TO BE COMPLETED BY CONSULTING PHYSICIAN / SURGEON) (IN CASE OF ADVERSE MEDICAL HISTORY)

1. Name of the Insured				
2. HISTORY (a) Present complaints and Investigation, if any (b) Any past history of disease, Operations, accidents, Investigations with date, major Medical complaints of Hospitalisation (c) Details of present and past Medication with duration (d) (d) Is he cured of diseases, if any ? When was your treatment , If any, Given , stopped ?				
3. General Examination				
4. Systematic Examination				

Signature of Consulting Physician
Name of consulting Physician
Qualifications
Address
Telephone Number

Signature of Proposer
Date:
Place:

Signature of Insured