# Aditya Birla Health Insurance Company Ltd.

(A part of Aditya Birla Capital Ltd.)

ADITYA BIRLA CAPITAL

PROTECTING INVESTING FINANCING ADVISING

## Activ Fit (Young Adult Product) - Proposal Form

Application No.-Barcoded.:

1. Please select the appropriate options and fill the form in BLOCK LETTERS.
2. All details marked with (*) are mandatory.
3. Please disclose all facts and mention each information that may affect our decision to issue a policy or its price, terms, conditions, exclusions, truthfully and accurately as incorrect information may lead to policy cancellation/ claim rejection. The Policy shall become void at our discretion, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure of any material fact, particularly in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the proposer or any one acting on his behalf. If You are in any doubt, please seek the advice of your insurance advisor.
4. The policy would be incepted only after complete premium including loading premium (if applicable) is submitted by You & there may be break in period (during which You are not covered) in case of Portability proposal. Hence is it advisable to extend your porting policy with existing insurer with short period basis until the proposal is accepted & issued by us in case of portability request.
5. The Proposer must authenticate each cancellation/ alteration in this form.
6. Plan designed for digital & non digital portals.

Customer ID: ______________________ Branch Stamp: ______________

Reference No: ABHI/PROD/21-22/RHI/25

### I. Proposer Details:

**Gender*:** ☐ Male ☐ Female ☐ Other **Date of Birth*:** D D M M Y Y Y Y

| | |
|---|---|
| **Name*:** | First* Middle Last* |
| **Whether employee of Aditya Birla Group** | ☐ Yes ☐ No Employee ID: |
| **Whether Employee of Affiliate** | ☐ Yes ☐ No Employee ID: Name of Affiliate: |
| **Correspondence Address*:** | **City*:** **Town (District):** **State*:** **PIN Code*:** |
| **Contact Details*:** | Mobile Number*: Emergency/Alternate Contact No.: Name and Relation: WhatsApp No., If Different From Mobile Number: |
| **Email ID*:** | (All proposal/policy related communications will be sent on this e-mail id) |
| **Identification Type*:** | ☐ Aadhar Card ☐ PAN Card ☐ Passport ☐ Driving License ☐ Others Please mention ID Number |
| **PAN:** | (PAN is mandatory in case premium is > Rs 1,00,000 (irrespective of the mode of payment of premium) Or > Rs 50,000 accepted in Cash) |
| **GST Registration Status*:** | ☐ Consumer ☐ Registered Dealer ☐ Compounding Dealer Please specify GST Identity Number: ______ (mandatory for Registered dealer & Compounding dealer) |
| **Annual Income*:** | ☐ Up to 5 L ☐ 5 to 10 L ☐ 10 L to 20 L ☐ >20 L |
| **Educational Qualification*:** | Below Matric ☐ Matric ☐ Graduate ☐ Post Graduate ☐ Diploma ☐ Professional Degree ☐ Others ☐ (Specify) |
| **Occupation*:** | Government Employee ☐ Private Service ☐ Business ☐ Housewife ☐ Retired ☐ Professional CA ☐ Doctor ☐ Lawyer ☐ Others ☐ |
| **Marital Status*:** | ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Seperated |
| **Nationality*:** | ☐ Indian ☐ Non Resident Indian ☐ Foreign National with Indian Origin ☐ Person of Indian Origin ☐ Others <Specify> |

Activ Fit (Young Adult Product), Product UIN: ADIHLIP22008V012223.

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## II. GO Green & What'sApp Consent*:

☐ I would like to contribute in creating a healthier, greener and cleaner environment by authorizing Aditya Birla Health Insurance Co. Limited to send all my Policy & Service related communication to the Email ID mentioned in this application form.

☐ I choose to have hardcopy of Policy Documents.

(In case hard copy of policy document is required, the same will produced to the Insured person anytime during the Policy Period)

To serve you better, we will use WhatsApp Channel to send you updates about your Proposal/Policy with Us. You hereby give consent to and authorize Aditya Birla Health Insurance Company to send you communication via WhatsApp Channel. We respect your privacy and will ensure that promotional content is not shared through this channel. ☐ Yes ☐ No

## III. Product / Plan Details*:

| | |
|---|---|
| **Tenure*:** (Discount applicable on 2 & 3 year tenure) | 1 Year ☐ 2 Years ☐ 3 Years ☐ |
| **Cover*:** | Individual ☐ Family Floater ☐ |
| **Plan Details** | Plus ☐ Preferred ☐<br>Note – Preferred Plan is not available on Individual/ Multi Individual Policy |
| **Sum Insured (Rs)*** | 1 Lac ☐ 2 Lac ☐ 3 Lac ☐ 4 Lac ☐ 5 Lac ☐ 7 Lac ☐ 10 Lac ☐ 15 Lac ☐<br>20 Lac ☐ 25 Lac ☐ 30 Lac ☐ 40 Lac ☐ 50 Lac ☐ 75 Lac ☐ 1 Cr. ☐ |
| **Mode of Premium Payment*:** | ☐ Monthly Instalment ☐ Quarterly Instalment ☐ Half Yearly Instalment ☐ Single |
| **Optional Cover** Additional premium applied | (i) Travel Protect ☐ Option 1 ☐ Option 2<br>(ii) Premium Waiver ☐<br>(iii) EMI Protection ☐<br>(iv) Super No Claim Bonus ☐<br>(v) Non - Medical Expense waiver ☐<br>(vi) OPD Expenses ☐<br>(vii) Reduction in Maternity Waiting Period^ ☐<br>Note - Optional Cover Premier Waiver & Reduction in Maternity Waiting Period can be opted only at the inception of the policy & not available at the time of renewal/portability/migrated cases. |

## IV. Insured Details*:

☐ Is Proposer also the Insured

| Particulars | Insured 1 | Insured 2 | Insured 3 | Insured 4 | Insured 5 | Insured 6 |
|---|---|---|---|---|---|---|
| **Name*** | | | | | | |
| **Relationship with Proposer*** | | | | | | |
| **Gender*** | | | | | | |
| **Date of Birth*** (dd/mm/yyyy) | | | | | | |
| **Nationality*** | <Country> | <Country> | <Country> | <Country> | <Country> | <Country> |
| **City of Residence*** | | | | | | |
| **Height*** (cms) | | | | | | |
| **Weight*** (kgs) | | | | | | |
| **Sum Insured*** (Multi Individual policy) | | | | | | |
| **Email ID*#** | | | | | | |
| **Mobile Number*#** | | | | | | |
| **PAN Card (Optional)** | | | | | | |
| **Aadhar Card (Optional)** | | | | | | |
| #(Mobile Number and Email id is mandatory for each adult insured. In case the contact number is not available, please mention the contact number of proposer) | | | | | | |
| **Optional Benefits** | (For Multi Individual Policy please tick against insured who wants to opt for it) | | | | | |
| **Travel Protect** | ☐ Plan 1<br>☐ Plan 2 | ☐ Plan 1<br>☐ Plan 2 | ☐ Plan 1<br>☐ Plan 2 | ☐ Plan 1<br>☐ Plan 2 | ☐ Plan 1<br>☐ Plan 2 | ☐ Plan 1<br>☐ Plan 2 |
| **Premium Waiver** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **EMI Protection** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Super No Claim Bonus** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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| | | | | | | |
|---|---|---|---|---|---|---|
| **Non - Medical Expense waiver** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **OPD Expense** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Note - Discount applicable**

1) Early bird discount (Applicable if Insured age at entry is between 18 - 35 years) –
   5% discount from 4th policy year to 7th policy year.
   10% discount from 8th Policy year onwards.
2) Family Discount
   2 members in a policy – 5% discount on applicable premium
   3 or more members in a policy – 10% discount on applicable premium.
3) Long Term Discount
   7.5% on selecting a 2 years policy
   10% on selecting a 3 years policy
   (Long term discount will apply only in case of Single Premium Policies)
4) Standing Instruction Discount - 2.5% Discount on the premium from 1st renewal, if the premium is received through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card).
5) Direct Purchase Discount - 10% discount if the insured member opts to purchase the policy directly from the Company's website without the involvement of any intermediary.
6) Online Intermediary Discount - 10% discount if the insured member opts to purchase the policy using an online intermediary.
7) Affiliate Employee Discount - 10% discount would be offered on the policies which are purchased by employees of intermediaries of Aditya Birla Health Insurance Co. Ltd.
8) Employee Discount - 10% discount would be offered on the policies covering employees and/or family members of employees of Aditya Birla Group.
9) Upfront Good Health Discount – 10% applicable on your First Year Policy Premium: ☐

Note - Online Intermediary Discount, Employee Discount, Affiliate Employee Discount and Direct Purchase Discount are available on mutually exclusive basis.

## V. Previous/ Current Insurance Details:

Do you have **Previous/ Current** Policy or Proposal applied for life/ health/ hospital daily cash/ critical illness / cancer or personal accident insurance?* ☐ Yes ☐ No
If Yes, Please fill the following details with respect to Insurance Policies(s) currently held with Us or any other Insurance Company.

| Sr. No. | Previous/Current Insurance Details: * | Insured 1 | Insured 2 | Insured 3 | Insured 4 | Insured 5 | Insured 6 |
|---|---|---|---|---|---|---|---|
| 1 | **Insurer Name & Policy Number** | | | | | | |
| 2 | **Claim in Previous Policy (Yes/No)#** | | | | | | |
| 3 | **Was any proposal/policy declined/ deferred / withdrawn / accepted with modified terms/ cancelled, if "yes" please provide details in additional information (Yes/No)** | | | | | | |
| 4 | **Do You want to consider this Health policy for Portability## (Yes/No)** | | | | | | |

**# If Claims in Previous Policy is "Yes", Please mention details of Claim in 'Information On Health And Lifestyle' section**
**## In case you want Portability of your Previous Policy, kindly fill the Portability form separately.**

## VI. Nominee Details*:

| Nominee Name | Nominee Relationship with Proposer | Nominee Contact Number |
|---|---|---|
| | | |
| **Appointee Details: (Required only if nominee is a minor)** | | |
| Appointee Name | Relationship with Nominee | Age |
| | | |

Note - A Minor should not be declared as Appointee.

## VII. Information On Health And Lifestyle:

Please answer the following questions in "Yes" OR "No" with respect to all persons proposed to be insured. **Note -Please answer all below mentioned questions for each Insured. Please attach discharge card / summary, all consultation papers, investigation reports, histopathology reports, disability certificate from civil surgeon, if any.**

| **A.** Have you ever been diagnosed with /advised / taken treatment or observation is suggested or undergone any investigation or consulted a doctor or undergone or advised surgery or hospitalized for any one or more from the following?<br>**If YES, then please mention details in the additional information section below:** | Insured 1 | Insured 2 | Insured 3 | Insured 4 | Insured 5 | Insured 6 |
|---|---|---|---|---|---|---|
| * Any form of Heart Disease, Peripheral Vascular Disease, procedures like Angioplasty/PTCA/By Pass Surgery, valve replacement etc<br>* Diabetes, High blood pressure, High Cholesterol, Anaemia / Blood disorder (whether treated or not).<br>* Asthma, Tuberculosis (TB), any Respiratory / Lung disease<br>* Disease of Eye including but not limited to Cataract, Ear, Nose, Throat, Thyroid disorder | | | | | | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| *Cancer, Tumour, lump, cyst, ulcer<br>*Disease of Kidney, Digestive tract, Liver/Gall Bladder, Pancreas, Breast, Reproductive /Urinary system, or any past complications of pregnancy/ child birth including high blood pressure or diabetes etc.<br>* Mental illness, Psychiatric/psychological disorder.<br>*Disease of the Brain/Spine/Nervous System, Epilepsy,<br>*Paralysis, Polio, Joints/Arthritis/prolonged back pain<br>*Congenital/ Birth defect, Genetic Disease/Physical deformity/disability, Polio, Obstructive sleep apnea (OSA), Peripheral vascular disease i.e Blockage of Upper or lower limb artery/vein, Varicose Veins<br>*HIV/AIDS, other Sexually Transmitted Disease or Accidental injury or any other medical (other than common cold & viral fever) or surgical condition or Investigation parameter has been detected to be out of range/ not normal? | | | | | | |
| **B**. Are you suffering from or had suffered in past, any of below conditions? **If YES. then please mention Details in the additional information section below.** | | | | | | |
| Nephropathy | | | | | | |
| Retinopathy | | | | | | |
| Neuropathy | | | | | | |
| Diabetic Foot | | | | | | |
| Stroke | | | | | | |
| Malignant Hypertension | | | | | | |
| History of Renal Artery Stenosis | | | | | | |
| History of Pheochromocytoma | | | | | | |
| History of Aneurysm | | | | | | |
| History of Peripheral Vascular Disease | | | | | | |
| Chronic Obstructive Pulmonary Disease (COPD) | | | | | | |
| **C.** Has any of the persons proposed to be insured | | | | | | |
| a. Under any regular medication prescribed by the Doctor other than vitamin pills and tonics? | | | | | | |
| b. Blood tests, X-Ray/USG/Scan/MRI in the last 5 years other than routine or pre-employment health check? | | | | | | |
| c. Surgery done or advised and still pending for the surgery to be done? | | | | | | |
| **D.** Do you consume any of the following substances?<br>(if yes, please mention the quantity) | | | | | | |
| Alcohol [30ml ( number of pegs) of hard liquor/ pints of beer/ glass of wines] per week. (YES/NO) | | | | | | |
| Smoking (Number of Cigarette/bidi sticks) **per week** (YES/NO) | | | | | | |
| Pan Masala/Gutkha (Number of small Pouches) **per week** (YES/NO) | | | | | | |
| Any Other substance (Name & Quantity) **per week** (YES/NO) | | | | | | |

**Additional Information:** Please attach extra sheets if required

| Details | Insured | | | | | |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| Disease name | | | | | | |
| Date of Diagnosis | | | | | | |
| Last Consultation Date | | | | | | |
| Name of Surgery (if any) | | | | | | |
| Details of Treatment given (Hospitalization/OPD, other) | | | | | | |
| Disability % | | | | | | |
| Period of Hospitalization (if any) | | | | | | |
| Any Other Information | | | | | | |

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## VIII. Premium Payment Details:

**Mode of Premium Payment:**

☐ Cash ☐ Cheque ☐ Demand Draft ☐ Pay Order ☐ Credit Card ☐ Debit Card ☐ Online

☐ IMPS/ NEFT/ RTGS ☐ E-Wallet ☐ UPI

| Instrument Number | Instrument Date | Instrument Amount (₹) | Name of Premium Payer** | Relationship of Payer with Proposer | Bank Details (Bank Account Number, Bank Name, IFSC code) |
|---|---|---|---|---|---|
| | | | | | |

** Income Tax benefit under section 80D of Income Tax Act, is available to the person who pays the health insurance premium by other than cash payment mode for himself and his family member (Spouse, dependent children & parent). Eligibilities under section 80D are subject to Income Tax Act.

## IX. Bank Account Details*:

Mandatory details required to process all payment due in relation to your Policy including refunds# (if any) and / or claims directly to your bank account.

Name as in Bank Account: ____________________

Bank Name: ____________________ Account Number: ____________________

IFSC Code: ____________________

Account Type (Current/Saving): ____________________

In case of payment through Debit Card, Credit Card and Online Mode of payment, the refund will go back to the same card or bank account as the case may be.

**Date:** D D M M Y Y Y Y

**Place:** ____________________ **Signature:**

**NACH / E NACH / Standing Instruction Mandate:**

☐ I would like to avail the renewal premium payment facility by mandating ABHI to debit my premium through NACH/E NACH/ Standing Instruction.

For availing NACH duly filled and signed physical NACH mandate to be submitted.

Note – You will be eligible for 2.5% Online Renewal discount on the renewal premium, if the renewal premium is received through NACH/Standing instruction (where payment is made either by direct debit of bank account or credit card)

## X. Declaration & Authorization*:

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 to 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.

Date:__________ Place: ____________________ Signature: ____________________

**Cookies:**

Aditya Birla Health Insurance uses the technology known as "cookies" to track usage patterns, traffic trends and user behaviour, as well as to record other information from the website. For certain services provided on this website, cookies allow Aditya Birla Health Insurance and/or its group companies/affiliates to save information locally so that you will not have to re-enter it the next time you visit. Many content adjustments and customer service improvements are made based on the data derived from cookies. The information we collect from cookies will not be used to create profiles of users and will only be used in aggregate form.

The User may set his/her/its browser to refuse cookies. If the User so chooses, the User may still gain access to most of the Website, but the User may not be able to conduct certain types of transactions (such as shopping) or take advantage of some of the interactive elements offered.

If the User uses any of the sharing features that may be offered by this Site, the User's friend's email address will not be retained on Aditya Birla Health Insurance Website or used in any way by Aditya Birla Health Insurance or its group companies/affiliates

## XI. Vernacular Declaration:

I hereby declare that I have fully explained the contents of the proposal form and all other documents incidental to availing the health insurance from Aditya Birla Health Insurance Company 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. Replies have been read out to, fully understood and confirmed by the Proposer.

Declarant Name: ____________________ Declarant Signature: ____________________ Date: __________

Proposer Name: ____________________ Proposer Signature: ____________________

Proposer Sign Date: ____________________ Place: ____________________

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## XII. Insurance Advisor Report:

**Business Source Channel (Please tick the channel applicable and fill details in BLOCK letters)**

☐ Agency ☐ Corporate Agency ☐ Direct Sales ☐ Broker ☐ Other Channels

| **Intermediary Details** | | | |
|---|---|---|---|
| Intermediary Name: | Intermediary Code: | Ref Code 1: | Ref Code 2: |
| Relationship between Advisor and Proposer/Insured | | | |
| SP Code (For Corporate Agency channel only) | | | |
| RM/LG/Ref Code (For Corporate Agency channel only) | | | |
| Sales Manager Name (for All Channels) | | | |
| Sales Manager Code (For All Channels) | | | |
| **ABHI Branch Details (to be filled for all channels)** | | | |
| Intermediary Branch Name | | | |
| Intermediary Branch Code | | | |

I, ______________________________________________________ in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised 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 and that any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer. 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, or if there has been a non-disclosure of any material fact, the policy issued in his/her favor pursuant to this Proposal may be treated as null and void by the Company and all premiums paid under the Policy may be forfeited to the company. I confirm that the proposal form is filled accurately by the customer to the best of my knowledge.

Date: ____________

________________________________
Signature of Agent
(Insurance Advisor Signed date cannot be prior to Customer's Signed date)

Reference No: ABHI/PROD/21-22/RHI/25

## XIII. ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER (E-mail id is mandatory):

Do you have an EIA Account: ☐ Yes ☐ No

If Yes, please quote EIA Account Number: ______________________________________________

Please mention name of Insurance Repository (IR): __________________________________________

If No, do you want Us to create an EIA account for you: ☐ Yes ☐ No (if Yes, please fill up Insurance Repository Application Form)

Email Id (Registered with Insurance Repository) : _____________________________________

Your address details as mentioned in the EIA account shall override the address provided in this application for Insurance.

**Section 41 of Insurance Act 1938 (Prohibition of rebates):**

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 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 prospectus or tables of the insurers.

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.

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**Aditya Birla Health Insurance Co. Limited. IRDAI Reg.153. CIN No. U66000MH2015PLC263677.**
Product Name: Activ Fit (Young Adult Product), Product UIN: ADIHLIP22008V012223.
Address: 9th Floor, Tower 1, One World Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013. Email: care.healthinsurance@adityabirlacapital.com, Website: adityabirlahealthinsurance.com, Telephone: 1800 270 7000. 

Contact us:
1800 270 7000

ADITYA BIRLA CAPITAL

## XIV. Acknowledgement

Application Number : ____________________

We acknowledge with thanks the receipt of your application and amount by Cash/Cheque/Demand Draft/ Others ________________________ of amount of

Rs. ___________________________ dated ___________________________ 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, post deduction of applicable pre-policy check up charges if any, received from you without interest.'We do not have any liability of claim until the proposal is accepted by us, counter offer if any accepted by you & policy is issued'.

Name of the Branch Official : __________________________________________________

Signature of Branch Official : _______________

Date : ___________