

No. 17556/821/CO-HR

Date: 31.03.2026

Sub: BERECHS – Voluntary Top-up Health Insurance Policy 2026-27 reg.
Ref: Circular No. 17556/821/CO-HR dated 18.03.2026

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- 1.0 The details of the Top-up Policy under BERECH Scheme provided by M/s. United India Insurance Co. Ltd. (UIICL) was notified vide Circular referred above.
- 2.0 Further, to the above referred Circular it is hereby brought to the notice of all BERECHS members that the last date for enrolment has been extended upto **03.04.2026**
- 3.0 The Enrolment process and Enrolment form for availing the top-up facility is enclosed for reference. The premium to be paid is indicated in the Enrolment form and the member has to pay the premium directly to the Insurer i.e., M/s. UIICL.
- 4.0 The completely filled-in Enrolment form should be sent to rajesh.k@mediassist.in and belsupertopup@gmail.com. Further, it may be noted that members enrolling and making payment after 31.03.2026, the coverage shall not be available for the intervening break-in period.
- 5.0 For any clarifications w.r.t. enrolment process, payment issues, etc., the following are the Single Point of Contact (SPOC):

Name	Unit / Office	Contact no.
Rajesh K	Bangalore & Corporate Office	8197416211
Charu Saini	Ghaziabad & Delhi Offices	7618791817
Anand K	Other Units	9952051768

- 6.0 All Units / Offices may note the above and widely disseminate the same to the Retired Employees Association / Members of the scheme.


DGM(HR-P&ER)

UNIT HR HEADS

RO / MC HEADS

UNITED INDIA INSURANCE CO. LTD.

(A Government Of India Enterprise)

LARGE CORPORATE AND BROKERS CELL

BEL RETIRED EMPLOYEES GROUP HEALTH INSURANCE VOLUNTARY TOP UP POLICY

ENROLLMENT PROCESS

This document is to assist the Retirees of BEL to opt for the Voluntary Top Up Policies. This is a Top Up Policy for Hospitalization (In-patient). The Top up Policies are available only to Retirees covered under the BEL Group Health Policy for Retirees.

The cover under the Top Up policies shall be the same as in the BEL Group Health Policy for Retirees. The claim under the Top Up Policies shall trigger only after the exhaustion of the sum insured limits under the Primary policies.

Enrollment Form: The Sum Insured limits and their corresponding premium for various category of Retirees is given in the Enrollment Form. The enrollment form should be completed in all respects. Incomplete forms and illegible forms may be rejected. The completed Enrollment Form shall be emailed to rajesh.k@mediassist.in & belsupertopup@gmail.com and in case of assistance; members can contact 9980146859 between 10:00 AM to 5:00 PM on working days.

Hospitalization Top Up Policy: Retirees opting for the Hospitalization Top Up policy should put a tick (✓) against the eligible sum insured limit in Para 3 of Enrollment Form.

Premium: The retiree shall remit the applicable premium including GST as per the amount arrived at in Para 3 of Enrollment Form to the Bank Account whose details are given below by IMPS/ NEFT/ RTGS. Please note that this is a Virtual Bank Account number. It is in the following format and has space for 22 characters.

ZUIICL500400XXXXXXXXXBEL

OR

200999095210500400XXXXXXXXXBEL

The first 12 digits are fixed and should not be changed. The Next 7 digits which is shown as XXXXXXXX represents the Retiree's New Staff Number provided by BEL. The Retiree shall fill in his / her New 7-digit Staff Number here. Retirees having only 6-digit New Staff Number can enter only those 6 digits. The next 3 digits is fixed and should not be changed.

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Please ensure that the account number is entered in the above format only and New Staff Number is correctly entered. If the format is changed or the New Staff Number is incorrectly entered, then the premium paid by the Retiree will not be traceable and may lead to denial of cover.

As explained above, the premium should be transferred to this bank account.

Beneficiary Name	United India Insurance Co. Ltd.
IFSC	INDB0000007
MICR CODE	600234002
Bank Name	IndusInd Bank
Branch	Nungambakkam, Chennai
Account Type	Current
Account Number	ZUIICL500400XXXXXXXXXBEL OR 200999095210500400XXXXXXXXXBEL

Important: After making the premium payment to the above bank account the details of your bank, UTR number and date of payment should be filled in Para 6 of the Enrollment Form.

Email: The completely filled in enrollment form should be then **scanned** and emailed to rajesh.k@mediassist.in & belsupertopup@gmail.com There is no need to send physical form to us.

Assistance: For any clarifications or assistance in filling up the form or in transferring the premium amount, please call **9980146859** between **10 AM and 5 PM** on working days.

United India Wishes You Good Health

Making a payment using a bank account number and IFSC code through UPI apps is a convenient alternative when the recipient does not have a UPI ID or QR code. This method uses the **Immediate Payment Service (IMPS)** infrastructure to ensure the transfer is instant and available 24/7.

General Steps for Most UPI Apps

While the interface may vary slightly between apps like Google Pay, [PhonePe](#), and [Paytm](#), the core process remains the same:

1. **Open the App:** Launch your preferred UPI-enabled application.
2. **Select Transfer Option:** Look for an option labeled **"To Bank A/c"**, **"Bank Transfer"**, or **"To Bank/Self A/c"** on the home screen.
3. **Enter Recipient Details:**
 1. **Account Number:** Enter the recipient's full bank account number. You will often be asked to re-enter it for confirmation.
Note: Please refer last page for account number
 2. **IFSC Code:** Enter the 11-digit IFSC code **INDB0000007**
 3. **Account Holder Name:** United India Insurance Company Limited
4. **Enter Amount:** Input the sum you wish to transfer.
5. **Select Source Account:** Choose which of your linked bank accounts you want to pay from.
6. **Authenticate with UPI PIN:** Enter your secure 4 or 6-digit **UPI PIN** to authorise the transaction.
7. **Confirmation:** Once successful, you will receive an instant notification and a transaction receipt.

Step-by-Step for Popular Apps

App	Navigation Path
Google Pay	Tap "Bank transfer" > Enter Account No., IFSC, and Name > Tap "Continue" .

Paytm Tap "To Bank A/c or UPI ID" > Select "Enter Bank A/c No. & IFSC" > Enter details and tap "Proceed".

PhonePe Tap "To Bank/Self A/c" > Tap the "+" icon > Select the Bank > Enter Account No. and IFSC > Tap "Next".

BHIM/Axis Pay Select "Send Money" > Choose "A/c + IFSC" > Enter details > Tap "Proceed".

Important Tips for Safe Transfers

- **Double-Check Details:** Even a single wrong digit in the account number can lead to the money being sent to the wrong person.
 - **Verification:** Many apps now automatically fetch the account holder's name after you enter the account number and IFSC; always verify this name before hitting "Pay".
 - **Transaction Limits:** Direct bank transfers via UPI typically follow standard limits, often capped at ₹1,00,000 to ₹2,00,000 per day depending on your bank.
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**BEL RETIRED EMPLOYEES GROUP HEALTH
INSURANCE VOLUNTARY TOP UP POLICY
ENROLLMENT FORM 2026-27**

1 Please provide complete details of the Retiree of BEL. Please write legibly.

Name of the Retiree			
New Staff Number			
Grade		Category	
Mobile Number			
Email ID			
Address for Communication			

2 Please provide the details of persons to be enrolled under the Voluntary Top Up Policy

Sl	Name	Relationship	Gender	Age	Tick if Covered
1		Retiree			
2		Spouse			

3 Please tick the applicable Limit as per your Grade and Family Size, if Opted for In-Patient Top Up

HOSPITALISATION (IN-PATIENT) TOP UP Premium including 18% GST																					
Single Member (TH)					TOPUP SI																
Category	BERECHS Sum Insured	2 lakhs	Tick, if Opted	4 lakhs	Tick, if Opted	6 lakhs	Tick, if Opted	8 lakhs	Tick, if Opted	10 lakhs	Tick, if Opted	14 lakhs	Tick, if Opted	16 lakhs	Tick, if Opted	18 lakhs	Tick, if Opted	20 lakhs	Tick, if Opted	25 lakhs	Tick, if Opted
III	300000	10493		12591		15109		NA		NA		NA		NA		NA		NA		NA	
II	375000	9444		11332		13598		16318		NA											
II A	487500	8500		10199		12239		14686		NA											
I	600000	7649		9179		11014		13217		15862		19033		22840		27408		32890		39467	
IA	600000	7266		8720		10464		12556		15069		18081		21698		26038		31245		37495	
Family (TH)					TOPUP SI																
Category	BERECHS Sum Insured	2 lakhs	Tick, if Opted	4 lakhs	Tick, if Opted	6 lakhs	Tick, if Opted	8 lakhs	Tick, if Opted	10 lakhs	Tick, if Opted	14 lakhs	Tick, if Opted	16 lakhs	Tick, if Opted	18 lakhs	Tick, if Opted	20 lakhs	Tick, if Opted	25 lakhs	Tick, if Opted
III	400000	15866		19039		22847		27417		NA											
II	500000	14279		17136		20563		24675		29610		35532		NA		NA		NA		NA	
II A	650000	12851		15423		18506		22208		26649		31979		38375		NA		NA		NA	
I	800000	12209		14651		17581		21097		25317		30380		36456		43747		52497		62997	
IA	800000	10988		13185		15823		18987		22785		27342		32811		39373		47247		56697	

4 Please provide the premium paid details

Online Payment can be done by NEFT/ RTGS. The bank details of United India Insurance is provided in the attached 'Voluntary Top Up Enrollment Process Brochure'	
Amount Paid	
Name of the Bank from which premium paid	
UTR Number	
Date of Payment	

5 The Top Up Policy will be effective from 01/04/2026. Cover will be available only to those persons from whom the full premium has been received by the Insurer and coverage confirmation has been sent.

6 I hereby declare that the above information given by me are true to the best of my knowledge and I understand that the policy will be for a period of one year and that no withdrawal from the policy is allowed during the policy period.

Place:
Date:

Name & Signature of the Retiree / Spouse

United India Insurance Company Limited

Corporate Identity Number: U93090TN1938GOI000108
Registered Office: 24 Whites Road, Chennai – 600014
IRDAI REG NO.545



Super Top-up Medicare Policy

Proposal Form

Important Instructions

Please read the instructions below carefully before filling out this form

- This Proposal Form shall be the basis of the policy to be issued. Thus, please provide all the information sought in this Proposal Form & all additional relevant information fully & accurately. **Please do not leave any space blank or put dashes.**
- The Company will not be at risk until the Proposal has been accepted by the Company and communication of the acceptance has been given to the proposer in writing after payment of the requisite premium.
- Details of up to 6 Insured Persons, can be filled in this Proposal Form. For additional members, please use a fresh form.
- Pre-policy health check-up reports not older than 30 days must be submitted, wherever required at the Company's discretion.
- A person porting (switching) from a health insurance policy of other non-life insurance or stand-alone health insurance companies must complete Annexure C (Portability Form) along with Proposal Form, Annexure A and B (if required).
- A list of documents required is provided in Annexure D.

I. Proposer Details

Please submit a copy of your Proof of Residence as per Annexure D

Name: _____
Date of Birth: DD/MM/YYYY Gender: Male Female Other Marital Status: Single Married
Occupation: Salaried Self-Employed Others, please specify _____
PAN: _____ Aadhaar Card/Passport No: _____ E-Insurance Account No.: _____
(Or form 60/61) (if available)
Present Address: _____
City: _____ State: _____ Pin Code: _____
Permanent Address: _____
City: _____ State: _____ Pin Code: _____
Tel. No.: _____ Email ID: _____ Mobile: _____

II. Nomination

Where the Nominee is a minor, please give the details of the Appointee

The nominee mentioned below will be for the 1st Insured. For other members covered under the Policy, the 1st insured is deemed to be the Nominee

Nominee Name: _____ Nominee Relationship with the Proposer: _____
Present Address: _____
Permanent Address: _____
Bank A/c Number and IFSC: _____ Email ID: _____ Mobile: _____

III. Coverage Details

Coverage required from DD/MM/YYYY to midnight of DD/MM/YYYY

Policy Type: Individual Sum Insured Basis Family Floater TPA preference: _____

Sum Insured and Threshold Combination Options:

Threshold	SI Options
5 Lacs	5 Lacs, 10 Lacs, 15 Lacs, 20 Lacs, 45 Lacs, 70 Lacs and 95 Lacs
10 Lacs	10 Lacs, 15 Lacs, 20 Lacs, 40 Lacs, 65 Lacs and 90 Lacs
15 Lacs	15 Lacs, 35 Lacs, 60 Lacs and 85 Lacs
20 Lacs	20 Lacs, 30 Lacs, 55 Lacs, 80 Lacs
25 Lacs	25 Lacs, 50 Lacs, 75 Lacs

Important Note: Please enter the Threshold/SI combination you require in the table provided under Section IV (Insured Person Details). In case you are opting for policy on Family Floater basis, enter the Threshold/SI combination under Proposer only. In case you are opting for policy on Individual Sum Insured basis, enter the Threshold/SI combination for each of the Insured persons.

Daily Cash Allowance (Opt.): Yes No

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IV. Insured Person(s) Details

Paste one stamp size photograph and sign below. In case of minor, guardian or proposer may sign

1 st Insured Person's Photo	2 nd Insured Person's Photo	3 rd Insured Person's Photo	4 th Insured Person's Photo	5 th Insured Person's Photo	6 th Insured Person's Photo
Signature	Signature	Signature	Signature	Signature	Signature

	1 st Insured Person	2 nd Insured Person	3 rd Insured Person	4 th Insured Person	5 th Insured Person	6 th Insured Person
Name						
Date of Birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Gender	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> M					
ABHA ID						
Occupation						
Aadhaar No.
Sum Insured (if Ind Basis)						
Threshold (if Ind Basis)						
Height (cm)						
Weight (kg)						
Blood Group						
Relation w/ Proposer						
Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No					

ABHA Creation Declaration: I have read the terms of usage of Aadhar for the creation of ABHA Number as available at <https://healthid.ndhm.gov.in/register/aadhaar>. I consent to the usage of my/our Aadhaar Number(s) by UIIC for the creation of my/our ABHA number(s) through the National Health Authority (NHA). Yes No

V. Existing Health Cover Information

Does any person proposed to be insured presently hold a health insurance policy from any insurer (including UIIC)? Yes No
 If yes, please give details below.

	1 st Insured Person	2 nd Insured Person	3 rd Insured Person	4 th Insured Person	5 th Insured Person	6 th Insured Person
Company						
Policy No.						
Policy Type (Base/ Top-Up)						
Expiry Date						
Sum Insured						
Threshold						
Servicing TPA						
Last Claimed Date						
Claimed Amount						
Porting/Migrating						

Kindly fill Annexure C if insured is porting from another insurance company to our company.

Please note that the continuity of benefits shall NOT be considered if the above question is not replied in the affirmative, details are not provided and Portability Form (Annexure C) and relevant supporting documents are not submitted to UIIC.

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VI. Medical Information

Medical History of the person proposed for Insurance. Tick Yes/No. Please do not leave the spaces blank.

	1 st Insured Person	2 nd Insured Person	3 rd Insured Person	4 th Insured Person	5 th Insured Person	6 th Insured Person
Lifestyle Questionnaire						
Does any person who is proposed for insurance consume						
Alcohol	<input type="checkbox"/> Y <input type="checkbox"/> N					
Tobacco (Bidi/Cigarette/E- Cigarette/Gutkha/Pan Masala, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N					
If the answer is 'Yes' to any of the questions above, please give details below on the type and quantity consumed per week and consumption history (years) ➤ Alcohol – _____ ➤ Tobacco (Bidi/Cigarette/ E- Cigarette /Gutkha/Pan Masala, etc.) – _____						

Mental Health Questionnaire						
Has any person proposed for insurance ever faced the following psychological situations? Please provide details in the table below						
Diagnosed with or treated for any psychological or mental health condition?	<input type="checkbox"/> Y <input type="checkbox"/> N					
Undergone Hospitalisation or Psychological Counselling, or Psychotherapy for any mental health condition?	<input type="checkbox"/> Y <input type="checkbox"/> N					

Specific Condition Questionnaire						
Has any person proposed for insurance ever suffered from/are suffering from any of the following?						
Cardiovascular System Heart Diseases (e.g. Coronary Insufficiency, Congenital and Acquired Valvular Diseases, Cardiomyopathy, Congenital Heart Disease) OR Chest Pain, Heart Attack, Angina, Palpitations, OR Undergone Angioplasty/ Bypass Surgery OR Diagnosed with high Blood Pressure (BP) or Hypertension OR Paralysis, or any Blood Clotting disorder	<input type="checkbox"/> Y <input type="checkbox"/> N					
Respiratory System Asthma, COPD, Chronic Bronchitis, Tuberculosis, Pneumonia, Interstitial Lung Disease or any other chronic lung condition	<input type="checkbox"/> Y <input type="checkbox"/> N					
Digestive System Any disorder of the Stomach, Intestines, Liver, Gall Bladder, or Pancreas (e.g., Ulcer, Jaundice, Cirrhosis, Pancreatitis, Hepatitis, Chronic Liver Disease, Piles, Fissures, Fistula, Hernia, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N					
Genitourinary System Any diseases of the Kidney, Urinary bladder and Urinary tract. OR Any Prostate or Reproductive organ disorder (e.g. DUB, Fibroid uterus, Prolapsed uterus, Ovarian cyst, Benign prostate hypertrophy)	<input type="checkbox"/> Y <input type="checkbox"/> N					
Endocrine & Metabolic System	<input type="checkbox"/> Y <input type="checkbox"/> N					

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Diabetes (Type I or II) or Prediabetes, Dyslipidaemia, Thyroid-related disorders or any other chronic endocrine and metabolic related disorders.						
Nervous System Epilepsy, Seizures, Stroke or Any Neurological disorder (e.g., Parkinson's, Multiple sclerosis, Demyelinating disease, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N					
Musculoskeletal System Arthritis, Spinal Injury or Deformity, Avascular Necrosis or Fractures or any other Musculoskeletal disease/condition	<input type="checkbox"/> Y <input type="checkbox"/> N					
Skin & Connective Tissues Chronic Skin Conditions (e.g., Psoriasis, Eczema, Vitiligo, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N					
Haematological System Anaemia of any type, Thalassemia, Haemophilia, Bleeding/ Clotting disorders, or any other Blood condition	<input type="checkbox"/> Y <input type="checkbox"/> N					
Immune System / Autoimmune Disorders Lupus, Rheumatoid Arthritis, Inflammatory Bowel Disease, HIV or any other Autoimmune disease	<input type="checkbox"/> Y <input type="checkbox"/> N					
Oncology Cancer, Tumour, or Any Pre-Cancerous condition	<input type="checkbox"/> Y <input type="checkbox"/> N					
Eyes Any history of Vision loss, Glaucoma, Cataract, ARMD OR Requiring Visual Aids or Surgery OR Any other eye diseases	<input type="checkbox"/> Y <input type="checkbox"/> N					
ENT Any disease of the Ear, Nose or Throat	<input type="checkbox"/> Y <input type="checkbox"/> N					

Disability related Questionnaire

Is any person proposed for insurance suffering from any of the following condition/disability?

Locomotor Disability including Leprosy Cured Person, Acid Attack Victim, Cerebral Palsy, Muscular Dystrophy, and Dwarfism OR Visual Impairment, Hearing Impairment OR Speech and Language Disability OR Autism Spectrum Disorder OR Intellectual Disability (e.g., Down syndrome, Cognitive impairment)	<input type="checkbox"/> Y <input type="checkbox"/> N					
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General Medical Questionnaire

Does any person who is proposed for insurance ever suffer from/are suffering from any of the following: Please provide details in the table below

More than two Hospitalization in the previous two years except for hospitalizations for vector-borne, air-borne, and water-borne diseases with hospitalizations less than 5 days. Or Any Surgery/Treatment, consultations, investigations, or diagnostic tests planned or pending	<input type="checkbox"/> Y <input type="checkbox"/> N					
Experienced pain for more than 7 days in any part of the body OR Restriction of any movement OR Difficulty in swallowing or breathing OR Any difficulty in carrying out your daily activities? Or	<input type="checkbox"/> Y <input type="checkbox"/> N					

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Persistent headache or persistent cough OR Blood in stool or any bleeding from any other orifice/ body opening for more than 5 days?						
Currently taking any prescription medications or undergoing ongoing medical treatments?	Y N	Y N	Y N	Y N	Y N	Y N

If you answered 'Yes' to any of the prior questionnaires, please give details in the following table. Additionally, also submit Annexure A, B.

Name of the Person to be insured	Illness/Condition	Date of Last Consultation (DD/MM/YYYY)	Medication/Treatment(s) Undergone and Duration of the Treatment	Name of the treating Doctor	Hospital Name & Phone No.	Present Status

VIIPast Proposals

Has any proposal for life, health, or critical illness insurance for any of the persons proposed to be insured ever been declined, postponed, loaded, or made subject to any special conditions by any insurance company? If yes, please give the details.

Yes No

VIII. Bank Details for Processing of Refund

Bank Name: Branch Address:

Bank Account No: IFS Code:

Would you like to receive your insurance policy document in physical form, in addition to the electronic copy? Yes No

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IX. Declarations

- I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the statements, answers and/or particulars given by me/us are true and complete in all respects to the best of my knowledge and that I am authorized to propose on their behalf.
- 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 United India Insurance Company Limited and that the policy will come into force only after requisite receipt.
- I undertake to inform the Company in writing of any change in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before the communication of the risk acceptance by the company.
- I consent and authorize the Company to seek medical information from any doctor, hospital, or past or present employer concerning the health of the insured/proposer and from any insurer to whom an insurance application has been made, for underwriting and/or claim purposes.
- I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer with TPAs, Service Provider(s) of UIIC, reinsurers and/or any Governmental and/or Regulatory authority solely for underwriting, servicing, claims settlement, fraud detection or compliance with the applicable Law/ Regulations. I consent to United India Insurance Company Limited collecting, processing, storing, verifying, and sharing my/our personal and sensitive personal information, including medical records, strictly for the purposes mentioned above, in accordance with applicable laws, including the Digital Personal Data Protection Act, 2023. I acknowledge that I have been informed about the intended use of such information and provide explicit consent for the same.
- I authorize the company to access my/our information as available in my/ our Ayushman Bharat Health Account (ABHA) including the medical records for the sole purpose of proposal underwriting and/or claims settlement and share the same with TPAs, Service Provider(s) of UIIC and/or any Governmental and/or Regulatory authority and/or to comply with the applicable Law/ Regulations.

I also confirm that the source of funds for premium paid under this policy is legal.

Date: DD/MM/YYYY Place: _____ Signature of the Proposer: _____

Name of the Proposer (in BLOCK letters): _____

X. Certificate from Proposer in case Proposal form is not filled by them/The proposer signs in vernacular language/is illiterate

The proposal form is filled up by my representative [Name of the representative (in BLOCK letters) : _____], and the contents of the documents have been fully explained to me and I am willing to accept the coverage subject to terms, conditions and exclusions prescribed by the Insurance Company therein.

Date: DD/MM/YYYY Place: _____ Signature of the Proposer: _____

Please note that this should necessarily be signed by the proposer and not by his/her representative.

XI. Declaration of the Intermediary

I/We confirm that I/We have explained the product features to the proposer and its suitability to him/her and other insured persons.

Date: DD/MM/YYYY Place: _____ Signature of Intermediary: _____

XII. Statutory Warning (Section 41 of 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 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 the 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.
- Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

XIII. Office Use Only

Gross Premium: _____ Premium for Optional Cover: _____ Net Premium: _____

Intermediary Code: _____ Development Officer Code: _____

Acknowledgement by the Company

Date: DD/MM/YYYY

We acknowledge the receipt of your proposal and amount by Cash/Cheque/Others _____ for amount of Rs. _____

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 to make any payment 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 any payment received from you without interest within next 30 days.

This Annexure is to be completed by EACH insured person who has answered ‘Yes’ to any of the questions in Section VI (Medical Information) or has any pre-existing conditions/adverse history in respect of any illness.

Name of Insured Person:

Diabetes Questionnaire

- Date of 1st Diagnosis of Diabetes :
- Do you take any anti-diabetic drugs? :
- If so, please give name with dosage
- Please give details of fasting and postprandial blood sugar readings, E.C.G. findings & other investigation reports with date. Please also send reports :
- Please state whether you have been diagnosed with any complication of diabetes? :

Hypertension Questionnaire

- Date of 1st Diagnosis of Hypertension :
- What is your blood pressure reading? :
- Please state with dates
- Please state names of anti-hypertensive drugs with dosage details :
- Are you a smoker? :
- Is it essential/secondary/malignant hypertension? :
- Please state whether you have been diagnosed with any complication of hypertension? :
- Please give findings of all investigation reports :

Chest Pain or Coronary Insufficiency or Myocardial Infarction Questionnaire

- Date of 1st Diagnosis :
- Did you ever suffer from chest pain/coronary insufficiency/myocardial infarction? If so, please give diagnosis and date. :
- Please state the name and dose of drugs you are taking at present :
- 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. :
- Please state the date of hospitalisation and names of hospitals (attach last discharge summary) :
- Please state complications and other related disease, if suffered. :
- Please state whether you can do your regular work and whether you have any limitation of activity? :
- Are you advised any special treatment? If so, please give information :

Any other Pre-Existing Condition

- Nature of illness/disease/injury & treatment received :
- Date of 1st Diagnosis :
- Whether fully cured? :
- Please state the date of hospitalisation and names of hospitals. (attach last discharge summary) :

Date: DD/MM/YYYY

Place:

Signature of Insured Person:

This Annexure is to be completed by the consulting physician/surgeon if ANY of the insured persons have answered 'Yes' to any of the questions in Section VI (Medical Information) or have any pre-existing conditions/adverse history in respect of any illness.

• Name of the Insured Person :

History

• Present complaints and investigation, if any? :

.....
.....

• Any past history of disease, operations, accidents, investigations with date, major medical complaints of hospitalisation? :

.....

• Details of present and past medication with duration :

.....

• Is he/she cured of diseases, if any? :

When was your treatment, if any, given, stopped?

.....

• General Examination :

• Systematic Examination :

Signature of Consulting Physician

Signature of Proposer

.....

.....

Name of Consulting Physician:

Place:

Qualifications:

Date: DD/MM/YYYY

Address:

Telephone No:

Office Use Only

Do you consider the risk acceptable?

Competent Authority:

At Operating Office:

At Regional Office (If referred to RO):

This Annexure is to be completed by the policyholder who is porting from a health insurance policy issued by another insurance company

Name of Policyholder:

Policy No:

PORTABILITY FORM

1.	Name of the Insured(s)	
2.	Date of Birth	
3.	Address of the Policyholder	
4.	Details of Existing Insurer	
	a. Name of insurance company	
	b. Sum Insured	
	c. Cumulative Bonus	
	d. Add-ons/riders taken	
5.	Details of the Proposed Insurance	
	a. Name of the product proposed/intended to take	
	b. Sum Insured proposed	
	c. Whether Cumulative Bonus to be converted to an enhanced sum insured	
	e. Policy Number	
6.	Reason(s) for Portability	
7.	No. of family members to be included in the policy to be ported	
Enclosure: Photocopy of the existing & previous policy documents		
Date:		
		Signature of the Policyholder

- Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy? (Please indicate Yes / NO):
.....

- If Yes, please give written consent to the declaration below:

I am aware that the waiting period for the following disease(s)/treatment(s) is more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s).

Name of the Disease / Treatment	Waiting Period in Days / Years
1.	
2.	
3.	
4.	

Date: DD/MM/YYYY

Place:

Signature of Policyholder:

This Annexure details the list of documents that are required along with this proposal form and the documents that are considered as valid.

Documents Required

- Completed Proposal Form
- Cancelled Cheque (supporting bank account details)
- Stamp Size Photograph (2 no.) for each insured person
- Pre-Policy Check-up reports (if applicable)
- Copy of existing health insurance policies (if applicable)
- Proof of Identity (any one document listed below)
- Proof of Residence (any one document listed below)
- PAN Details (In case PAN not available, Form 60 or 61 as per Rule 114B of the Income-Tax Rule, 1962 must be submitted)

Documentary Proof

Features	Documents
Proof of Identity	<ul style="list-style-type: none"> i. Passport ii. PAN Card iii. Voter's Identity Card iv. Driving License v. Letter from a recognized Public Authority (as defined under Section 2 (h) of the Right to Information Act, 2005) or Public Servant (as defined in Section 2(c) of the 'The Prevention of Corruption Act, 1988') verifying the identity and residence of the customer vi. Aadhaar Card vii. Job card issued by NREGA duly signed by an officer of the State Government
Proof of Residence	<ul style="list-style-type: none"> i. Passport ii. Driving License iii. Aadhaar Card iv. Voter's Identity Card v. Job card issued by NREGA duly signed by an officer of the State Government vi. Letter issued by National Population Register containing details of name and address <p>Where the above documents do not have the updated address, the following documents shall be deemed to be valid documents for the purpose of Proof of Residence.</p> <ul style="list-style-type: none"> i. Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone, piped gas, water bill) ii. Property or Municipal Tax receipt iii. Pension or family pension payment orders (PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address iv. Current Photo Passbook with details of permanent/present residence address (updated up to the previous month) v. Current statement of bank account with details of permanent/present residence address (as downloaded) vi. Ration card vii. Valid lease agreement along with rent receipt, which is not more than three months old as a residence proof viii. Employer's certificate as a proof of residence (Certificates of employers who have in place systematic procedures for recruitment along with maintenance of mandatory records of its employees are generally reliable)
Proofs of both Identity and Residence	Written confirmation from the banks where the proposer is a customer, regarding identification and proof of residence