NATIONAL INSURANCE COMPANY LIMITED

BRANCH OFFICE : S.C.F. 40 - 41, Phase - 5, Mohali Phone: 0172- 2225700, Telefax: 0172-2262593

AGENCY CODE

Name Address & Tel. No of the Insured

Ankita
58, Mansingh Wala
Dehradun



		1	2	3	4
01.	Name of the Person Insured	Ankita	Ankita	Ankita	Ankita
02.	Age & Date of Birth	20/10/1992	20/10/1992	20/10/1992	20/10/1992
03.	Relation with Proposer				
4.	Profession (Service/Bussines/Student/H/W)	Service	Service	Service	Service
05.	Sex (Male / Female)	Female	Female	Female	Female
06.	Average Monthly Income				
07.	Income Tax PAN Number	BGYPA1878D	BGYPA1878D	BGYPA1878D	BGYPA1878D
08.	Name, Add. & Regd. No. of Medical Practitioner				
09.	Any Previous Insurance, PA or Mediclaim Insurer, Policy No & Period of Insurance				
10.	Any Proposal of this kind refused or higher premium charged				
11.	Are you in good Health	Yes/No	Yes/No	Yes/No	Yes/No
12.	If not, give details (Also give pre-existing Disease Detail)				

	MEDICAL HISTORY	1	2	3	4
13.	Have you ever Suffered from any of the diseases/illness	Yes/No	Yes/No	Yes/No	Yes/No
A.	Any nervous, mental or psychiatric disease	Yes/No	Yes/No	Yes/No	Yes/No
B.	Spinal disorder or paralysis of any kind (fainting episode, Blackout, fit)	Yes/No	Yes/No	Yes/No	Yes/No
C.	Fistula, piles, hernia, varicose veins	Yes/No	Yes/No	Yes/No	Yes/No
D.	Any disease of bones on joint including rheumatic disease	Yes/No	Yes/No	Yes/No	Yes/No
E.	Breast or any specific gynecological disorders	Yes/No	Yes/No	Yes/No	Yes/No
F.	Any respiratory or allergic disease	Yes/No	Yes/No	Yes/No	Yes/No
G.	Any disorder of the stomach ulcer Bowel or gall bladder, kidney stones	Yes/No	Yes/No	Yes/No	Yes/No
H.	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
I.	Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigation	Yes/No	Yes/No	Yes/No	Yes/No
J.	Any complaint or tendency that may necessitate such consultation or treatment in the future	Yes/No	Yes/No	Yes/No	Yes/No
K.	Any dimness or vision / cataract	Yes/No	Yes/No	Yes/No	Yes/No
L.	Any disease of ears or difficulty or interference with hearing	Yes/No	Yes/No	Yes/No	Yes/No
M.	Any other illness or disease or accident or operation sustained by you	Yes/No	Yes/No	Yes/No	Yes/No
N.	High Blood Pressure, Heart Diseases Including ishchaemic Heart Diseases order circulatory disorder etc.(Rheumatic Fever)	Yes/No	Yes/No	Yes/No	Yes/No
14.	A. Have you ever suffered from dental problems	Yes/No	Yes/No	Yes/No	Yes/No
	B. If yes specify same		Yes/No		
	C. When were your treatment last for same.				
15.	Give particulars in table below of any other illness or disease or accident or operation sustained by you in the past.				

	1	2	3	4
Nature illness/disease injury and treatment received				
Date first treated				
Name of attending medical practitioner, surgeon with his address and telephone no.				
whether fully cured	Yes/No	Yes/No	Yes/No	Yes/No

15 A.	Any additional facts affecting the proposed insurance. Which should be disclosed to the insurers?			
16.	Please give details of any knowledge of any positive existance or presence or any ailment, sickness or injury which may require medical attention.			
17.	SUM INSURED OPTED			

(Contd. on the back side)

Signature (Proposer)

Ankita (Signature) Ankita (Signature) Ankita (Signature) Ankita (Signature)

I hereby declare and warrant that the above statement are true and complete. I consent and authorise the insurers to seek medical information from any Hospital/Medecal 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 effected, it is found that the statement, answers or particulars stated in the proposal form and its Questionnaires and incorrect or untrue in any respect. the insurance company shall incur no liability under this insurance.

I have read the Prospectus and am willing to accept the coverage Subject to the terms, conditions and exceptions prescribed by the insurance company therein.

SIGNATURE OF PROPOSER

DIABETES QUESTIONNAIRE

DATE 27/07/2020

	1	2	3	4
1. Date of diagnoses of diabetes				
2. Did you suffer from coma or pro coma?				
3. Did you take any diabetic drugs If so please give names with dose	Yes/No	Yes/No	Yes/No	Yes/No
4. Please give details of Fasting and Postprandial Blood Sugar readings, ECG, Findings, Urine and other investigations reports with dates, Please also send reports.				
5. Do you suffer or have suffered from any complication of Diabetes or any other Deceases?				

HYPERTENSION QUESTIONNAIRE

	1	2	3	4
1. What is your Blood Pressure reading Please state with Dates				
2. Please state names of anti hypertension drugs with dose				
3. Are you a smoker	Yes/No	Yes/No	Yes/No	Yes/No
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 investigations report				

CHEST PAIN OR CORONARY INSUFFICIENCY OR MYOCARDIAL INFRACTION QUESTIONNAIRE

	1	2	3	4
1. Did you ever suffer from chest pain or coronary insufficiency or myocardial infraction? If so, please Give diagnosis & date				
2. Please state names 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 Hospitalization and names of Hospitals and consultants.				
5. Please state complication and other diseases if suffered.				
6. Please state whether you can do your regular work & whether you have any limitation of activity				
7. Are you advised any Special treatment? if so, Please give information				

ANNEXTURE-B(TO BE COMPLETED BY CONSULTING PHYSICIANSURGEON)

	1	2	3	4
1. Name of the Insured				
2. Present complaints and investigations, If any				
3. Any past history of diseases, operations accidents. Investigations with date, major medical complaints of Hospitalization				
4. Details of present and past medication with duration				
5. Is He/She cured of diseases, If any?				
6. When was your treatment if any given or stopped?				
7. General Examination				
8. Systematic Examination				

Date _____ Place _____ Signature of Proposer _____

Name of consulting Physician .....Qualifications ..... Phone .....

Rubber Stamp