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| 2000px-New_India_Assurance.svg.png   |  | | --- | |  | | ARBF COLOUR logo.png   |  | | --- | |  | |
| **PROPOSAL FORM** | |
| THE NEW INDIA ASSURANCE COMPANY LTD. | |
| AIBRF SUPER TOP UP HEALTH INSURANCE POLICY | |
|  |  |
| |  | | --- | | **PLEASE FILL ALL INFORMATION IN CAPITAL LETTERS** | | |
| **PLEASE TICK MARK IN APPROPRIATE BOXES AS APPLICABLE** | |
|  | |
| |  | | --- | | **Category : Officer** | |  |
| |  | | --- | | **Award Staff** | |  |
|  | **PLEASE PASTE PHOTOS** |
| **Name of proposer : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **UII Health Card No. : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Bank Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Correspondence Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| |  | | --- | | **City : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pincode : State : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  |
| **Email id : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| |  | | --- | | **Mobile No. :** | | |
| |  | | --- | | **Landline No. with STD Code :** | |  |
| **INSURED PERSONS DETAILS** | |
| **SELF** | **SPOUSE** |
| **Full Name : SELF** | **Full Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Date of Birth :** | **Date of Birth :** |
| **D D / M M / Y Y Y Y** | **D D / M M / Y Y Y Y** |
| |  | | --- | |  | |  |
| |  | | --- | | **Gender : M F** | | |  | | --- | | **Gender : M F** | |
| **Aadhaar Card No. :** | **Aadhaar Card No. :** |
| |  | | --- | |  | |  |
| |  | | --- | | **PAN Card No.:** | | |  | | --- | | **PAN Card No.:** | |
| **UII Health card ID no. : Same as above** | **UII Health card ID no. : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Name of nominee : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Name of nominee : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Relationship : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Relationship : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Bank Details:** | **Cheque Details :** |
| **Bank name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  | | --- | | **Amount : Rs.3511 / Rs.3806** | |
| **Account number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Cheque No. : \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **RTGS/NEFT/IFSC Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Bank Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **I have read the covers offered in the policy and hereby confirm my participation in the scheme for my family (self and spouse only) and undertake to pay the premium. I am aware that the insurance will be effective from 1st November, 2017 subject to full premium being paid.** | |
| **Note: Sum Insured under the policy is (i) For Officers -Rs.4,00,000/- (ii) For Award Staff - Rs.3,00,000/-** | |
| **Please attach below mentioned documents for each member including spouse :** | |
| |  | | --- | | **1. 2 passport/stamp photos each (please write name on reverse) 2. Health ID Card** | | |
| **Note : Please draw Cheque in the name of AIBRF** | |
|  | ............................................................................................... |
|  | (Signature of Insured) |
|  |  |