National Insurance Company Limited

Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071

PROPOSAL FORM CUM SCHEDULE FOR BARODA HEALTH

1. **Name of the Bank Branch**_____ **Agency Code No 9207010000**_____
2. **Name of the Customer**_____
3. **Type of Account (SB/CA/FDR/ Any other Pl. tick) and Account Number**_____
4. **PAN No.(if any)----------**
5. **Postal Address & Telephone No.**_____
   _____
   Pin Code _____
6. **Mobile No** _____
7. **Email ID -** _____
8. **Name and Address of the Medical Practitioner & Family Doctor(if any)**
   _____
   _____
9. **Date of Payment of Premium.**

Period of Insurance (one year from date of payment of premium)_____**to**_____**.**

10. **Sum insured per family:**

Sum Insured	Premium up to 65 Years	Premium above 65 years & upto 80 years
INR	Including Service Tax @15%	
50,000	953	1,191
1,00,000	1,790	2,237
1,50,000	2,700	3,376
2,00,000	3,473	4,341
2,50,000	4,158	5,198
3,00,000	4,845	6,056
4,00,000	6,044	7,556
5,00,000	7,246	9,056

Note: Premium amount is same irrespective of number of members joining the policy i.e. either the policy is taken for 1+1 or 1+2 or 1+3 or even one member only

11. **Details of Persons to be covered:**

Sr. No	Name of the insured person	Age	M/F	Relationship with account holder	Existing disease /Illness /Injury	Disease /Illness /Injury Suffered in the last 48 months
				A/c Holder		
				Spouse		
				Child 1		
				Child 2		

***Details may be given in a separate sheet, if space is not sufficient.**

12. Photographs of the insured Persons:

Account Holder	Spouse	Child – 1	Child – 2
D.O.B.	D.O.B.	D.O.B.	D.O.B.

(D.O.B. = Date of birth)

13. I have existing Medical insurance: Yes / No
If Yes, 1) Name of Insurer, Policy No., Period of Ins. _____

2) Sum insured _____

(In case of existing Mediclaim, settlement will be as per rules of the insurance company.)

14. Name of the Third Party Administrator : Given on separate page attached

I hereby declare and warrant that the above statements are true and complete. Myself and family members are maintaining good health subject to item no 9. I have read the salient features of the policy mentioned in the prospectus and willing to accept the coverage subject to the terms, conditions and expectations prescribed by the insurance company as per the agreement between Bank of Baroda and National Insurance Co. Ltd. I understand that in case of any claim under the policy, Bank of Baroda will not undertake any responsibility or will not accept any correspondence and the same have to be pursued with the insurance company / TPA only. I shall personally ensure renewal of the policy. I am aware that the policy will be renewed based on the premium rates, terms and conditions at the time of renewal. In the event of Govt. of India revising the Service Tax rates, I agree to pay the difference in Service Tax amount and for debiting the same to my account mentioned above.

I have read the terms and conditions of the scheme and I shall abide by the same.

Place :
Date : **Signature of the Proposer**

FOR OFFICE USE ONLY

Premium debited on _____ for Rs. _____

Place:
Date:

Signature of the Branch Manager

Originals with Photos to NICL mapped office

NOTE: 1) For scope of coverage, terms and conditions refer to the Baroda Health policy (enclosed)
2) For claim procedures refer to enclosed TPA Guidebook