

OneHealth Proposal Form

Proposal No. _____

1. FOR OFFICE USE ONLY			
Branch Name		Branch Code	
Intermediary Name		Intermediary Code	
Sales Channel Type		If POSP then please provide the below:-	
Proposal Received On		a) PAN Card Number of POSP:	
		b) AADHAR Card Number of POSP:	

GUIDELINES FOR COMPLETION OF THE FORM (TO BE FILLED BY PROPOSER)

Please answer all the questions fully and correctly. This proposal will be the basis of any insurance policy that We may issue. You must disclose all facts relevant to all persons proposed to be insured that may affect Our decision to issue a policy or its price, terms, conditions and exclusions. The policy shall become void at Our sole discretion, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular 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 there is insufficient space for you to provide information whether as requested or otherwise, please attach a separate sheet. If you are in any doubt, please seek the help of Our company representative or your insurance advisor. 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 under the Policy if premium is not received by Us in full and in time, or is not realized or non-fulfillment of pre-policy medical check-up or proposal is not accepted by Us.

All fields/details marked with * are mandatory.

2. PROPOSER DETAILS

Please fill up this form in CAPITAL LETTERS for yourself and each proposed insured person.

Proposer Name* (Mr./Ms./Mrs./Other)																			
Marital Status	☐ Single ☐ Married	(First Name)	(Middle Name) (Last Name)																
Gender	☐ Male ☐ Female ☐ None of these																		
Nationality*	Date of Birth* <table border="1" style="display: inline-table; text-align: center; width: 100px;"> <tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr> </table>	D	D	M	M	Y	Y	Y	Y										
D	D	M	M	Y	Y	Y	Y												
Occupation	☐ Salaried ☐ Self-employed ☐ Professional ☐ Others (please specify).....																		
Annual Income (in ₹)	☐ < 3,00,000 ☐ 3,00,000 – 10,00,000 ☐ 10,00,001 – 25,00,000 ☐ >25,00,000																		
Address for Correspondence*																			
Landmark																			
City:		State:	Pin Code:																
Phone No. STD Code	Landline No.	Mobile No.*	Email ID																
Are you a Magma Employee? ☐ Yes ☐ No If yes, Employee Code:																			
PAN No.* <table border="1" style="display: inline-table; text-align: center; width: 100px;"> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>										Aadhaar No. <table border="1" style="display: inline-table; text-align: center; width: 100px;"> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>									
ID Proof Type* ☐ PAN Card ☐ Passport ☐ Voter ID Card ☐ Driving License ☐ Aadhaar Card ☐ Others If others, please specify																			

* Mandatory if premium under this proposal is Rs. 50,000 or more

I/ We hereby give my/ our consent to the Company to verify and obtain my/ our identity/ address proof as well as the identity/ address proof of the insured through Central KYC Registry or UIDAI or through any other permitted modes for the purpose of undertaking applicable KYC. ☐ Yes ☐ No

3. PLAN DETAILS*

Policy Type	☐ Individual ☐ Family Floater	Policy Period	☐ 1 Year ☐ 2 Years ☐ 3 Years																
If Family Floater**, number of persons to be covered: Adults: ☐ Children: ☐ (**Max 4 Adults and 3 children)		Premium Payment Frequency	☐ Single Premium ☐ Quarterly Instalment ☐ Monthly Instalment ☐ Semi-annual Instalment																
Zone Opted:																			
Plan	☐ Support ☐ Secure ☐ Support Plus ☐ Shield ☐ Premium																		
Sum Insured (in Lacs)	<table border="0" style="width: 100%;"> <tr> <td>☐ 2L ☐ 3L</td> <td>☐ 2L ☐ 3L ☐ 4L</td> <td>☐ 2L ☐ 3L ☐ 4L ☐ 5L</td> <td>☐ 5L ☐ 7.5L ☐ 10L</td> <td>☐ 10L ☐ 15L ☐ 20L ☐ 25L</td> </tr> <tr> <td>☐ 4L ☐ 5L</td> <td>☐ 5L ☐ 7.5L ☐ 10L</td> <td>☐ 7.5L ☐ 10L ☐ 15L ☐ 20L</td> <td>☐ 15L ☐ 20L ☐ 25L</td> <td>☐ 30L ☐ 50L ☐ 1Cr ☐ 2Cr</td> </tr> <tr> <td></td> <td>☐ 15L ☐ 20L ☐ 25L</td> <td>☐ 25L ☐ 30L ☐ 50L</td> <td>☐ 30L ☐ 50L ☐ 1 Cr</td> <td>☐ 3Cr</td> </tr> </table>	☐ 2L ☐ 3L	☐ 2L ☐ 3L ☐ 4L	☐ 2L ☐ 3L ☐ 4L ☐ 5L	☐ 5L ☐ 7.5L ☐ 10L	☐ 10L ☐ 15L ☐ 20L ☐ 25L	☐ 4L ☐ 5L	☐ 5L ☐ 7.5L ☐ 10L	☐ 7.5L ☐ 10L ☐ 15L ☐ 20L	☐ 15L ☐ 20L ☐ 25L	☐ 30L ☐ 50L ☐ 1Cr ☐ 2Cr		☐ 15L ☐ 20L ☐ 25L	☐ 25L ☐ 30L ☐ 50L	☐ 30L ☐ 50L ☐ 1 Cr	☐ 3Cr			
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Aggregate Deductible option ☐ Yes ☐ No (If yes, please choose deductible option from below)																			
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☐ 1Cr	☐ 5L ☐ 10L																		
Voluntary Co-Payment ☐ Yes ☐ No (if yes, please choose option from below) ☐ 10% ☐ 20%		Hospital Cash Optional Cover ☐ Yes ☐ No																	
Bonus Booster ☐ Yes ☐ No		Maternity benefit optional cover ☐ Yes ☐ No																	
Enhanced pre & post Hospitalization cover ☐ Yes ☐ No		Home treatment additional daily cash optional cover ☐ Yes ☐ No																	
Non-payable expense Cover ☐ Yes ☐ No		OPD & Home Care for Covid-19 ☐ Yes ☐ No																	
Removal of Mandatory Co Pay ☐ Yes ☐ No		Air Ambulance Cover ☐ Yes ☐ No																	
Outpatient Cover ☐ Yes ☐ No		Reduction of First Thirty Days Waiting Period ☐ Yes ☐ No																	
Recharge Benefit for same illnesses (not available for Support plan) ☐ Yes ☐ No		Global Cover ☐ Yes ☐ No																	
		Extensive Post hospitalisation Benefit ☐ Yes ☐ No																	
		Waiver of Deductible (Available only if Aggregate Deductible option chosen; not available with Premium plan) ☐ Yes ☐ No																	

4. DETAILS OF INSURED PERSONS TO BE COVERED

Details	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7
Title							
Name*	(First Name)						
	(Middle Name)						
	(Last Name)						
Gender (Male/Female/None of these)							
Height* (cm)							
Weight* (kg)							
Eye Refractive Error Index (Left and Right Eye)							
Date of Birth*							
Relationship with Proposer*							
ABHA No.							
Occupation (Salaried/Self-employed/Professional/Others)							
Optional Cover: Critical Illness Cover							
Optional Cover: Personal Accident Cover							
Optional Cover: Home Care for Covid-19*	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000

*25,000 option available only with Premium plan

5. NOMINATION

Policyholder is the nominee for all Insured members. Below details are for nominee to Policyholder.

Name of Nominee	First	Middle	Last
Relationship with Proposer	Date of Birth		
Contact Number of Nominee			

If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship with Nominee	Contact Number of Appointee

6. EXISTING/PREVIOUS INSURANCE DETAILSIs the proposer or the persons proposed, already insured under or proposed for a health insurance policy with Magma General Insurance Limited or any other insurance company? ☐ Yes ☐ No

If YES, please indicate below the Policy/Application number(s) (Please mention application number in case of pending proposal.)

Since when are you continuously insured?:

Insured Person Name (First, Middle, Last)	Insurer Name	Policy No./ Application No.	Period of Insurance		Sum Insured (₹)	Claims details, if any
			From	To		
			DD/MM/YYYY	DD/MM/YYYY		

If you want to avail the portability benefit from your existing insurance policy, please also submit to Us (as an annexure to this proposal form) all the policy documents relating to the existing policy in addition to the information given above

7. MEDICAL AND LIFESTYLE INFORMATION*

SECTION A: Have any of the person proposed to be insured ever suffered from / are suffering from any of the following: Please tick 'YES' for insured person wherever applicable and provide details in Section B	Yes / No	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6	Insured Person 7
1. Hypertension History								
a) Duration								
b) Medication								
c) Dosage								
2. Diabetes Mellitus History								
a) Type 1 or Type 2								
b) Duration								
c) Medication								
d) Dosage								

	Yes / No	Insured Person No.
3. Heart and Circulatory Conditions/Disorders: chest pain, angina, high cholesterol/lipids, palpitations, congestive heart failure, coronary artery disease, heart attack, bypass surgery/angioplasty, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, varicose veins, thrombosis, blood disorders etc.?		
4. Urinary Conditions/Disorders: Blood in urine, urinary frequency, painful/difficult urination Kidney and/or Bladder infections, stones of urinary system, renal failure, dialysis or Any Other Kidney/Urinary Tract Or Prostate Disease		
5. Musculoskeletal Conditions/Disorders: Joint/back pain Arthritis, Spondylosis, Joint Replacement Or Any Other Disorder of Muscle/Bone/ Joint/ligaments, tendons or discs, gout, herniated disc, amputation/prosthesis		
6. Respiratory Conditions/Disorders: Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease COPD, chronic cough, coughing of blood, etc or any Other Lung / Respiratory Disease		
7. Digestive Conditions/Disorders: Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder or any Other Gastro Intestinal condition		
8. Cancer/Tumor - Benign Or Malignant tumor, Any Growth/Cyst, any Cancer		
9. Brain/Nervous System/ Psychiatric Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any Other Brain/ Nervous System Disease, Mental/Psychiatric disorder		

	Yes / No	Insured Person No.
10. Female Reproductive Conditions/Disorders: Pelvic pain, abnormal, menstrual bleeding abnormal PAP smear, endometriosis, Fibroid, Cyst/ Fibroadenoma, Bleeding Disorder, Pelvic infection Or Any Other Gynecological / Breast cysts/lumps/tumor		
11. Is any female person proposed to be insured pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate?		
12. Metabolic and Endocrine Conditions/Disorders: Adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, any autoimmune/genetic disorder		
13. Does the person proposed to be insured suffer from any chronic or long-term medical condition, or have any other disability, abnormality or recurrent illness or injury or unable to perform normal activities?		
14. Does the person proposed to be insured use tobacco products/cigarettes or drinks alcohol?		
15. Does any of the person proposed to be insured suffers from any infertility related condition?		
16. Has any person proposed to be insured consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s)/any psychiatric condition/ undergone any hospitalization/illness/surgery/ currently taking medication(s) for any condition or medical procedures (including diagnostic testing)		
17. Have you or any of the persons proposed to be insured been diagnosed with or undergone surgery for any of the following Critical Illnesses, prior to proposing for this cover - Cancer, Heart Attack, Coronary Artery, Bypass Graft, Heart Valve Replacement/ Repair, Coma, Kidney Failure, Stroke, any Transplant, Paralysis, Multiple Sclerosis, Motor Neurone Disease or HIV/AIDS		

SECTION B: Name and details of Illness / Medicine / Test / Surgery / Dioptr grade (for questions answered as yes in SECTION A above)	Date of Last Consultation	Doctor's Name	Hospital Name & Phone No.	Ailment Details
Insured Person 1:				
Insured Person 2:				
Insured Person 3:				
Insured Person 4:				
Insured Person 5:				
Insured Person 6:				
Insured Person 7:				

Any other details: -----

Please add additional sheets if required.

Section C: Important Notes:

- The information that you give to Us on this proposal form or in any supplementary information form or documentation supplied by you or on your behalf will influence Our decision to offer insurance and the terms upon which to offer it. Further, any policy We issue will be based on what you have communicated to Us. It is therefore important that your answers are complete and accurate in all respect.
- The questions in this proposal are indicative rather than exhaustive. You must provide Us with all information relevant to the risk to be insured, even if it is not the subject of a question in this proposal. If you are in any doubt as to what information should be given, you should liaise with your insurance advisor/ company.
- Acceptance of your proposal would be subject to receipt of complete medical reports (wherever applicable), medical underwriting and realization of full premium amount by the company and the insurance coverage will commence from the date of underwriting by the company.
- The list of exclusions/ inclusions and other policy details are indicative, for complete list and comprehensive details kindly refer policy wordings.

Section D: Family Physician details:

Name:	Contact No.:
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8. PAYMENT DETAILS

- Payment Details: Please tick (✓) Total Premium amount including GST (₹) _____ ☐ Cash ☐ Cheque/NEFT/DD Payment Option ☐ Digital Payment
 Cheque/NEFT/DD Number _____ Cheque/NEFT/DD Date Bank _____
- For payment of claims/refund through direct bank transfer, please provide the following details: (please enclose a cancelled cheque along with the proposal form)
 Name of the Account Holder _____
 Name of the bank _____ Branch _____ City _____
 Account Type _____ IFSC Code _____ Account Number _____

Declaration:

"I/We hereby declare and undertake that the amount paid by me/us as premium for aforementioned policy is out of my/our lawful and declared source of income."

Electronic Clearing Service (Debit Clearing) Mandate Form

Proposal No. _____ Policy: _____

To,

Magma General Insurance Limited, Development House, 24 Park Street, Kolkata – 700 016

Ref: Authorization of customer to remit funds/payments to <Bank Name> through Electronic Clearing Service

Customer Information:

a) Account Holder(s) Name (As appearing in the Bank Records)		
b) Bank Name	c) Bank Branch Name	
d) Address	e) Branch City	
f) Account Type	g) Account No.	
h) Ledger No./Ledger Folio No.	i) 9 Digit MICR Code	

Declaration:

I wish to avail the electronic clearing facility and hereby express my unconditional consent to debit premium for my health insurance policy applied vide proposal form no. _____ through participation in Electronic Clearing System (ECS). I, understand and agree that premium amount to be debited from my account may vary due to change in age bracket of the senior most member insured under the policy, change in applicable premium rates by the insurer, taxes and other statutory levies as may be applicable from time to time.

(Please refer to sales brochure for approximate premium details due to change in age applicable at the time of renewal)

I, hereby declare that the particulars given are correct and complete. I understand and accept that the transaction will be effected on the due date as opted by me in this form subject to the payment of premium on the policy (provided the day is a working day). If the transaction is delayed or not effective at all for reasons of incomplete or incorrect information, I/we would not hold the user institution responsible. I/We have read all the terms and conditions as are applicable for availing of this ECS Debit service from/through the user institution and agree to discharge the responsibility expected of me/us as a participant under the scheme.

I/We also hereby authorize representative of Magma General Insurance Limited carrying this ECS Debit Mandate Form to get it verified and executed by my/our Bank.

Place: _____

Date:

Signature of applicant _____

5. Proposer Declaration

(Certification where for any reason, the proposal and other connected papers are not filled in by the Proposer). The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract. The Proposal Form is filled by _____ under my instruction and I found it to be correct.

Date:

Signature of the Proposer: _____

6. AML Guidelines

1. I/we hereby confirm that all premiums paid / payable in future are from bonafide sources and not paid out of proceeds of crime and that such premiums are not disproportionate to my/our income. I / we understand that the Company has the right to call for documents to establish sources of funds and to cancel the insurance policy in case I / we are found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering law in India.

Date:

Signature of the Proposer: _____

Are you or any of the proposal applicants PEPs* or a close relative/associate of PEPs*? ☐ Yes ☐ No

If yes, please share the details of "Politically Exposed Persons" (PEPs):

* (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials.

2. Additional Information:Nationality: Indian ☐ Non-Indian ☐ If, Non-Indian, please specify Country: _____**3. Type of Organisation:** (Applicable where an organisation is the proposer. In case of proposer being Individual, Sole Proprietor or HUF, please select option X)

- (i) Corporations (ii) Trust (iii) Government (iv) Partnership / LLP (v) Non-Government Organisations
 (vi) Co-operatives (vii) Society (viii) Private Limited Company (ix) Public Limited Company (x) others, please specify: _____

4. Source of Funds for premium payment:

Business: _____ Salaried: _____ Others (please specify) _____

7. Credit Score Consent

I authorize Magma General Insurance Limited to send this information to the Company designated credit scoring agency via a private and secured service to fetch my credit report and I agree to the consent terms of both the entities.

I authorize use of insights from my credit reports by Magma General Insurance Limited to offer me personalized products.

Date:

Signature of the Proposer: _____

11. GENERAL INFORMATION**1. Caution**

You are obliged to make a full and frank disclosure of all facts material to the assumption of risk in relation to you and every person proposed to be insured that would influence Our decision to issue the policy or the terms on which it is issued and you must not misrepresent any information to Us. The obligation continues until the policy is issued and does not end with the submission of this proposal form. If, therefore, there is any change in the information given herein or new information comes to light before the policy is issued, then you must inform Us of the same in writing without delay. If there is insufficient space to provide additional information, whether as requested or otherwise, then please attach an extra sheet duly signed. If the disclosure obligations are breached then such breach may render any policy issued void.

Prohibition of Rebates Under Section 41 of Insurance Law (Amendment) Act, 2015

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 the premium shown on the policy nor shall any person taking out or continuing the policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.
2. If any person fails to comply with sub-regulation (1) above, he shall be liable to payment of a fine which may extend to Ten Lakh Rupees.

Acknowledgment

Proposal No. _____

Date:

We acknowledge with thanks the receipt of your proposal and amount by Cash/Cheque/NEFT/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 after deducting the charges for pre-policy health checkup, if any, received from you without interest.

Signature of the receiver and office seal _____