दि न्यू इन्डिया एश्योरन्स कंपनी लिमिटेड
(सम्पूर्णतः भारत सरकार का उपक्रम)
बैंक एश्योरन्स मं. का. 131200, न्यू इन्डिया सेंटर, आठवी मंजिल, 17/ए, कूपरेज रोड, मुंबई 400 039.

Marketed By :

Union Bank of India
Good people to bank with

The New India Assurance Co. Ltd.
(Wholly owned by the Government of India)
Bancassurance D.O.No. 131200, New India Centre, 8th Floor, 17/A, Cooperage Road, Mumbai 400 039. Tel. : 2202 1180, 2202 2539, 2202 1134. Fax : 2202 0776. Email : a.jain@newindia.co.in

Application to join 'Union Health Care' Scheme

Sr.No	Name of insured person (Full Name In BLOCK LETTERS	Gender M / F	Date Of Birth			Relation with Account Holder	Floater Sum Assured (in Rs.)	Specify Name & period existing illness / disease/disablement	
			DD	MM	YYYY			Particulars	Existing From (Month & Year)
1									
2									
3									
4									

Note: 1. All the columns need to be filled; otherwise we will not be able to process your request
2. Please note that names found in the form only will be considered for insurance coverage
3. The Name under first row has to be of the senior most member and aged above 18 years
4. Male child (Son) age upto 21 years & unmarried Female child (Daughter) age upto 25 years could be considered dependents & permissible to be part of policy.
5. I confirm that I have read the terms of the policy carefully.

Name of the Proposer: ....

Address: ....
....
.... PIN ....

Period of Insurance: From .... To: ....

Occupation: .... Monthly Income Rs..............................

Contact No: .... Mobile No .... e-mail: ....
Bank A/C No: ....
Union Bank Branch Name & IBR Code: ....
Details of existing Mediclaim Insurance, if any: (Please attach a copy of the policy)

Insurer: .... Policy No: ....
Policy Period: ....

Declaration: I declare that all the persons proposed for Union Health Care Mediclaim Insurance include my spouse and dependent children and myself only. I also declare that none of them suffer from any pre-existing ailment which is not fully cured and that I have explicitly given information on such instances of pre-existing illness/disease/disablement separately, if applicable. All the information given in this form on behalf of my family members and myself is correct and true to the best of my knowledge and belief and shall be the basis on which insurance is granted. The New India Assurance Co Ltd reserves the right to delete / alter the terms and conditions of the scheme.

I have read and agreed to the terms & conditions of this scheme.

Date: ....

Place: .... (Signature of Proposer)

Photograph of Insured Persons:

1Name: .... 2. Name: .... 3. Name: .... 4. Name: ....

Please paste passport size colour photocopy of **Self (Proposer).** Please write the name of the insured person above	Please paste passport size colour photocopy of **Spouse.** Please write the name of the insured person above	Please paste passport size colour photocopy of **First Child.** Please write the name of the insured person above	Please paste passport size colour photocopy of **Second Child.** Please write the name of the insured person above

(Proposals accepted based on these reports does not prejudice the rights of the insurer to disclaim liability in respect of any preexisting disease whether disclosed or not)

Assignment: I .... do hereby assign the money payable by The New India Assurance Co Ltd in event of my death to Mr/ Ms .... My .... and I further declare that his/her receipt shall be sufficient discharge to the company.

Dated this .... Day of.................... 20 at ....

Signature of witness: .... (Signature of Proposer)

Name & Address: ....

....

(FOR BRANCH USE ONLY)

Premium calculation & Payment Details:-

No of Members (1/2/3/4)	Floater Sum Assured (in Rs.)	Annual Premium (in Rs.)	Service Tex (in Rs.)	Total Premium (in Rs.)	Premium Payment Detail	
					Transaction ID	Date Of Transaction