M/s.The New India Assurance Co.Ltd.
BANGALORE DO-3
2nd Floor, Mahalaxmi Chambers, M.G.Road, Bangalore-560001;
Tel.No.(080) 25584443, 25584297;
DO Email: nia.670300@newindia.co.in

CAN-MEDICLAIM POLICY

GROUP MEDICLAIM INSURANCE RENEWAL FORM FOR CANARA CARDHOLDERS (FOR THOSE WHO ALREADY HOLD CAN MEDICLAIM POLICY WITH M/S.UNITED INDIA INSURANCE CO.LTD.)

1) Name of the Proposer
2) Address of the Proposer
3) Name and address of the Medical Practioner/Family Doctor
4) Sum Insured per Family:[Tick( )Sum Insured chosen]

a)1Lac		b)1.5Lacs		c) 2Lacs		d)2.5Lacs		e)3Lacs	
f)3.5Lacs		g) 4Lacs		h) 4.5Lacs		i) 5Lacs		j) 6Lacs	
k)7Lacs		l) 8lacs		m)9lacs		n)10lacs			

5. Scheme Chosen: Scheme-A(1+3) Scheme-B(1+5)

6. Details of Persons to be covered:

(CardHolder, Spouse, DependentChildren and Dependant Parents of the Canara Cardholder)Coverage for dependent Children-Max 2Nos.only.

Sl. No.	Name of Insured Person	Date of Birth	Sex	Relationship with Proposer
1				
2				
3				
4				
5				
6				

7. Stampsized Color photographs of the Insured Persons to be affixed:

Card Holder	Spouse	Dependent Child-1	Dependent Child-2	Dependent Father	Dependent Mother

8) Details of past mediclaim lnsurance you or other family members have had:

Name of the member	Insurer	Policy No.	Sum Insured	Period of Insurance From	To

Your present Can-mediclaim Insurance details:

a) Policy No:
b) Existing sum Insured:

I/We hereby declare that the information given above are true and correct to my knowledge. I/We are sound in health (physical and mental) and am/are devoid of any illness/disease. I/We have read the contents of the brochure of the policy and have noted the same. I/We accept that the brochure forms part of the Proposal form. I/We agree that the insurance beings ought is only for the persons named in the proposal form. I/We also agree that the proposal if not received by the insurers on or before 10th of the month, policy period shall commence from the 1st day of the second subsequent month only subject to remittance of premium from Creditcard Account. I/We also declare that the insurance being sought is only for the persons as defined by you iny our brochure. I/We hereby agree to forfeit all rights to claim in case of any misrepresentation/suppression of facts by us and the policy may be cancelled at the option of the Insurer.

I hereby give my consent for debiting the premium chargeable for the policy from my Canara card Account and agree Canara card issuers' are in no way responsible for claims or other matters related with insurer. Participation is purely on voluntary basis and the contract of Insurance shall be with the Insurance Company and not with Canara Bank.

CanCard No.....Expiry Date.....

E-mail id:

Telephone

No.MobileNo.

Place: **Signature of the Cardholder:**

Date:

	CANARA MEDICLAIM PREMIUM FROM 1STJULY2017													
PLANA	PLANA FROM 36YEARS TO 80YEARS INSURED,SPOUSE AND 2DEPENDENTCHILDREN(1+3)													
SUMINSURED	1Lak	1.5Lak	2Lak	2.5Lak	3Lak	3.5Lak	4Lak	4.5Lak	5Lak	6Lak	7Lak	8Lak	9Lak	10Lak
MEDPREM	1724	2525	3248	3877	4529	5090	5650	6213	6774	7561	8822	10083	11343	12603
PAPrem	42	63	84	105	126	147	168	189	210	309	432	605	847	1186
18%ST	318	466	600	717	837	943	1047	1152	1257	1417	1665	1924	2194	2482
Total	2084	3054	3932	4699	5492	6180	6865	7554	8241	9287	10919	12612	14384	16271

PLANB	PLANB UPTO80 YEARS INSURED,SPOUSEAND2DEPENDENT CHILDREN & PARENTS(1+5)													
SUMINSURED	1Lak	1.5Lak	2Lak	2.5Lak	3Lak	3.5Lak	4Lak	4.5Lak	5Lak	6Lak	7Lak	8Lak	9Lak	10Lak
MEDPREM	2907	4256	5473	6554	7635	8579	9523	10472	11415	14718	17958	21907	26728	32606
PAPrem	42	63	84	105	126	147	168	189	210	309	432	605	847	1186
18%ST	531	777	1000	1199	1397	1571	1744	1919	2093	2705	3310	4052	4964	6083
Total	3480	5096	6557	7858	9158	10297	11435	12580	13718	17732	21700	26564	32539	39875