



दि न्यू इंडिया एश्योरन्स कंपनी लिमिटेड

THE NEW INDIA ASSURANCE COMPANY LIMITED

पंजीकृत एवं प्रधान कार्यालय : न्यू इंडिया एश्योरन्स बिल्डिंग, 87, महात्मा गांधी मार्ग, फोर्ट मुंबई - 400 001.

Regd. & Head Office : New India Assurance Bldg. 87, M.G. Road, Fort, Mumbai - 400 001.

Ph. : (022) 22708100, 22708400, Fax : 022-22700470, Telegram : NIASURANCE, Website : www.newindia.co.in

CIN No. : U99999MH1919GOI00526

PORTABILITY DECLARATION FORM

- Name of Insured :
- Type of Existing Insurance : Individual sum insured / Floater sum insured
- If policy copy is not attached, please fill up the following details of existing insurance.

Sr. No.	Name of Member	Sex	Age (Yrs)	Sum Insured (Rs.)	C.B.	Inception of 1st Insurance	Existing Insurer
1.		M / F					
2.		M / F					
3.		M / F					
4.		M / F					
5.		M / F					

- Name of existing Insurance product Policy Period
- Please furnish claims History of Expiring Policy and two years prior to it.

Sr.No.	Name of Claimant	Nature of illness	Claim Amount (Rs.)	Year of claim
1.				
2.				
3.				

- If the sum insured is enhanced please specify the details :

Sr.No.	Name of member	Amt. of original S. I. (Rs.)	Enhanced S. I. (Rs.)	Date of Enhancement

- Are you suffering from any chronic / recurring illnesses or diseases (Refer Table B) If 'Yes' Please Provide the details

- Are you suffering from Hypertension ? If yes, from when ?

- Are you suffering from Diabetes ? If yes, from when ?

Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy ? (Please indicate Yes / No.)

2. If yes, please give written consent to the declaration below :

I am aware that the waiting period for the following disease (s) / treatment (s) is more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease (s) / treatment (s).

Sr.No.	Name of illness / Disease	Waiting Period
1.		
2.		
3.		

I hereby declare that the above information given is true and correct to the best of my knowledge or belief. No information has been concealed or misrepresented or suppressed which is material to this proposal and which can have a bearing on its acceptance / denial.

Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non -co-operation by the insured will nullify the cover under the policy.

Place :

Date :

Signature of the Policyholder

(Name of the Policy holder in full)