TATA AIG MediCare Select
Proposal Form

URN No.: AH/2024-25/HL-09

Proposal no._____ Intermediary Code: _____

This is an application for insurance and issuance of this does not amount to acceptance of proposal by us. Commencement of risk under this proposal is subject to acceptance of the risk by us and receipt of premium.

The information declared by you in this form is the basis for issuance of the policy. Please answer all questions carefully. Any incomplete, incorrect or partially correct answers may lead to rejection of the proposal and also might lead to cancelation of policy.

Please fill-up this form in CAPITAL LETTERS

1. PROPOSER'S DETAILS

(Mr /Mrs /Ms /Dr)	First Name	Middle Name	Surname

Date of Birth (dd/mm/yyyy)		Gender	Male / Female/Others
Mobile		Unique Govt ID No.	
Alternate Mobile		Pan Card No.	
Annual Income (in ₹ lakhs)	Upto 3 / 3 to 6 / 6 to 10 / 10-15/ 15-20/ 20-25/ >25		
Occupation	☐ Salaried ☐ Self Employed ☐ Unemployed ☐ Retired/Student/Homemaker		
Marital Status	☐ Single ☐ Married ☐ Widowed ☐ Divorced		
E-Mail ID			
Residential address in India^			
Landmark		Area	
City/Town		Pin Code	

District		State	
Nationality	☐ Indian ☐ Foreign Nationals		
Permanent Address	☐ If same as Residential Address in India, please tick here		
Landmark		Area	
City/Town		Pin Code	
District		State	

Is Nationality or Residence Status of either the Proposer or any of the Insured Person(s) is 'other than India' (i.e. Nationality or Residence Status is Non Resident Indians (NRI) / Overseas Citizen of India (OCI) / Foreign Nationals)? ☐ Yes ☐ No

^Note:

- Here 'Address' implies the place where the person ordinarily resides. In case proposed prospect(s) reside at multiple addresses, then address of the person residing in the highest zone to be provided.
  Zone definitions as mentioned in the prospectus (wherein Zone A is highest followed by Zone B and Zone C respectively)
- Declared 'Address' will form the basis for the calculation of the premium.
- 'Address' is a material fact for calculation of the premium. "Material facts" for the purpose of this Policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.
- Any misrepresentation or misdescription of the same or established fraud by the policyholder may lead to termination of the policy as per policy terms and conditions and accordingly all premium paid thereon shall be forfeited to the Company.

☐ TATA Group Employee	Employee ID:
☐ Salaried employee of Public or a Private Company *By selecting, I hereby provide my consent for the verification of my employment status with the Employees' Provident Fund Organisation (EPFO), solely for the purpose of verifying the information relevant to this proposal.* *Professional E-Mail ID*_____	
☐ Any existing policy with TATA AIG General Insurance Co. Ltd.	Product Name: Policy No (s).:

2. POLICY DETAILS

Proposed Policy Commencement Date :

d	d	m	m	y	y	y	y

Policy Tenure ☐ 1 Year ☐ 2 Year (5% premium discount) ☐ 3 Year (7.5% premium discount)

Sum Insured Type:

☐ Floater ☐ Individual ☐ Multi-Individual (5% premium discount)
When more than one member are covered on individual basis

Floater Sum Insured (in ₹ Lakhs): ☐ 5 ☐ 7.5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 50 ☐ 75 ☐ 100 ☐ 200 ☐ 300

No Claim Bonus: ☐Cumulative Bonus ☐ Discount in Renewal Premium (No Claim Bonus)

You will have an option to choose Cumulative Bonus or Discount in Renewal Premium (No Claim Bonus) at the time of renewal of the policy.

Room Category: ☐ Single Private Room ☐ Twin Sharing ☐Any Room
Your Premium shall be based on choice of Room Type that You make at the time of Proposal.

Optional Covers:

S. No.	Benefits	Yes (Y) / No (N)
1	Consumables Benefit	Y/N
2	Infinite Advantage	Y/N
3	Early Access	Y/N
4	Aggregate Deductible	Deductible options (In. ₹) ☐ 10,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000

Note:

i. Aggregate Deductible is an cost sharing requirement under this policy which provides that We will not be liable for a specified amount in case of hospitalization/s during the policy year i.e. We will pay only if aggregate

admissible claim amount in respect of hospitalization/s during the policy year exceeds the aggregate deductible as specified in the policy schedule. An Aggregate Deductible does not reduce the Sum Insured.

ii. *Optional cover 3 is only available for polices with tenure 2 years or 3 years. This cover is not available for policies where premium is to be paid in installments.*

Riders for <<product name >> (UIN:<<>>):

Rider Package Name	Rider Name	Cover/ Benefit Name	Coverage Limit
☐ <<Package 1>>	<<Name of the Rider 1>> <<UIN 1>>	<<Coverage Name 1>>	<<Coverage Limit options>>
		<<Coverage Name 2>>	<<Coverage Limit options>>
	<<Name of the Rider 2>> <<UIN 2>>	<<Coverage Name 1>>	<<Coverage Limit options>>
		<<Coverage Name 2>>	<<Coverage Limit options>>
	<<Name of the Rider 3>> <<UIN 3>>	<<Coverage Name 1>>	<<Coverage Limit options>>
		<<Coverage Name 2>>	<<Coverage Limit options>>
	<<Name of the Rider 4>> <<UIN 4>>	<<Coverage Name 1>>	<<Coverage Limit options>>
	<<Name of the Rider 5>> <<UIN 5>>	<<Coverage Name 1>>	<<Coverage Limit options>>

3. DETAILS OF THE PROPOSED PERSON(S) TO BE INSURED

Sr. No.	**Name of the Proposed Insured Person**	**Gender**	**Relationship with Proposer***	**Date of Birth**	**Height**	**Weight**	**ABHA Number (14 digits) ^^**	**Individual Sum Insured (In. ₹)#**	Aggregate Deductible (In. ₹)	**Maternity Care**	**Reduction of Maternity Care Benefit Waiting Period (to 1 Year)**
1.		M / F/Others		dd/ mm/ yyyy	(cms)	(Kgs)			☐ 10,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000	Y/N	Y/N
2.		M / F/Others		dd/ mm/ yyyy	(cms)	(Kgs)			☐ 10,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000	Y/N	Y/N
3.		M / F/Others		dd/ mm/ yyyy	(cms)	(Kgs)			☐ 10,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000	Y/N	Y/N

4.		M / F/Others		dd/ mm/ yyyy	(cms)	(Kgs)			☐ 10,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000	Y/N	Y/N
5.		M / F/Others		dd/ mm/ yyyy	(cms)	(Kgs)			☐ 10,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000	Y/N	Y/N

*Allowed Relations

Family Floater: Self, Spouse (Same or opposite gender), Dependent Children, Parents/Parents-in-law.

Individual: Self, Spouse/ Partners, Dependent Children, Parents/Parents-in-law, Grandparents, Grandchildren, Siblings (Sister/Brother), Uncle, Aunt, Nephew, Niece, Employee, Domestic Help, Legal Guardian

For coverage of the below mentioned relationships, submit the listed documents:

Relationship	**Documents to be submitted**
Employee	Employment letter
Domestic Help	Declaration Form for Domestic Help Coverage
Legal Guardian	Legal guardianship certificate

^^Note: If ABHA Number is not available, we urge you to visit https://abdm.gov.in/ for creation of ABHA ID and inform the same to us once created.

4. NOMINEE DETAILS

In the event of the death of the Proposer any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions.

Details/Particulars	Name of the Nominee 1	Name of the Nominee 2
Date of Birth[1]		
Relationship		
Present Address of the Nominee		
Permanent Address of the Nominee	☐ If same as Present Address, please tick here	☐ If same as Present Address, please tick here
Mobile		
Email ID		
Percentage Share for Claim Amount Payable		
Bank Details of the Nominee		
Name of the account holder		
Name of the bank		
Branch Bank		

Account no.		
Bank IFSC code		
Account Type	☐ SB Account ☐ Current Account ☐ Others (please specify)	☐ SB Account ☐ Current Account ☐ Others (please specify)

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

Appointee Name	Relationship	Address of the Appointee

5. EXISTING/PREVIOUS INSURER DETAILS

Is the proposer or any of the persons proposed, already Insured under a health plan with TATA AIG General Insurance Company Ltd. or any other insurer or is a proposal pending for Policy issuance? If yes, please indicate the Policy/Application number(s): _____

Since when continuously insured:

D	D	M	M	Y	Y	Y	Y

Do you want Us to consider these details for portability? ☐ Yes ☐ No

Please note that continuity of benefits shall NOT be considered if the details are not provided. You need to approach Us at least 30 days prior to your expiry date to avoid any break in coverage. Please submit all previous year insurance policy copies.

Policy No.	Name of Proposed Insured Person	Insurer	Period of Insurance		Sum Insured & Cumulative Bonus (₹)	Aggregate Deductible **(₹)**	Claims lodged during the preceding years along with the diagnosis
			From	To			
			DD/MM/YYYY	DD/MM/YYYY			
			DD/MM/YYYY	DD/MM/YYYY			
			DD/MM/YYYY	DD/MM/YYYY			
			DD/MM/YYYY	DD/MM/YYYY			
			DD/MM/YYYY	DD/MM/YYYY			
			DD/MM/YYYY	DD/MM/YYYY			

6. MEDICAL AND LIFESTYLE DETAILS

A. Medical History:

Please answer the below mentioned questions individually in Yes(Y)/No (N): You must answer the questions truthfully. Not doing so would lead to termination of your policy.

Please answer each of the following questions individually for each proposed Insured Person by ticking the relevant box.	Proposed Insured Persons				
	1	2	3	4	5
<<Have you or any of the persons proposed for insurance, ever suffered from or taken treatment, or hospitalized for or have been recommended to take investigations / medication / surgery or undergone a surgery for the following medical conditions?>>					
<<☐Chest Pain / Heart Disease/Insulin Dependent Diabetes >>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐Arthritis>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐COPD>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐Kidney Failure, Dialysis>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐Liver Cirrhosis/Hepatitis B or C>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐Cancer>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐HIV/AIDs>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐Stroke, Epilepsy, Paralysis>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐Psychiatric, Mental Illness or disorder>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐Ulcerative Colitis/Crohn's disease>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐Auto-immune diseases>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<☐STDs>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Any other illness/disease/injury/disability in the past other than for childbirth, flu or for minor injuries that have completely healed?>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Are you or any persons proposed on regular medication (including any Ayurvedic treatment) or Hospitalized for any illness/ surgery or awaiting any procedure/treatment?>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Do you have any signs, symptoms, illness or injury including knee joint ligament tear or back pain/ Swelling or Pain in any part of body / Breathlessness on mild effort / dizziness more than once in last 6 months for which medical consultation / treatment / investigation has been required.>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Have you ever been diagnosed with any of these medical conditions with or without any follow-up tests/medications? – Elevated Blood Sugar/ Type 2 Diabetes Mellitus/ Elevated Blood Pressure/ Hypertension/High Cholesterol/ Asthma/ >>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N

<<Have you or any members ever been diagnosed with Thyroid Disorder? If yes, please provide details for follow-up tests/medications>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Is any of the proposed insured pregnant currently? If yes, please mention expected date of delivery (EDD). Any history of pregnancy related complications?>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<EDD: DD/MM/YYYY>>					
<<Has any application for life, Health or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Has any health or life insurance policy ever been terminated in the past?>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Have you undergone any annual health check-up or routine medical examination in the past year which showed any significant findings? If yes, please provide details for findings or results	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Have you ever been diagnosed with any of these medical conditions with or without any follow-up tests/medications? – Hypothyroidism/Depression/Anxiety/Thalassemia minor/Fatty Liver Grade 1/Existing implant in case of fracture>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Does any of the insured currently have, or have they been diagnosed with, Polycystic Ovarian Disease (PCOD) or any related conditions?>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
<<Is there any one in the family (parents/ siblings) with history of critical illness? For eg. Cancer? Please provide details of the same>>	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N
Has the baby been diagnosed with and/or treated for any disease / illness during the gestation and /or post delivery period. If yes, please share the relevant Ante natal records, maternity discharge summary, investigation reports, treatment documents.	Y/ N	Y/ N	Y/ N	Y/ N	Y/ N

B. Detailed information in case any of the questions in section 6 (A) is ticked 'Yes'.

(Please send us medical documents along with this application form.)

<<Proposed Insured Name>>	<<Name of Disease(surgical)>>	<<Operative status>>	<<Type of surgery >>	<<Treatment status>>	<<Complication(s)>>

<<Proposed Insured Name>>	<<Name of Disease(medical)>>	<<Date of diagnosis>>	<<Medication history>>	<<Mode of medication>>	<<Progress>>	<<Complication(s)>>

Proposed Insured Name	Remarks

C. Lifestyle Information

Does any person proposed to be insured smoke or consume Gutka/Pan Masala or Alcohol? Yes/No

If yes please indicate the name and quantity per day.

	Proposed Insured Person				
	1	2	3	4	5
<<Alcohol (in ml) • Per day • Per week • Per month • Occasionally>>	Quantity + Frequency+Duration				

<<Smoking (No of Cigarettes or Bidis) • Per day • Per week • Per month • Occasionally>>	Quantity + Frequency+Duration				
<<Pan Masala/Tobacco (in gms) • Per day • Per week • Per month • Occasionally>>	Quantity + Frequency+Duration				
<<Others habit forming substances/addictive (Quantity consumed) • Per day • Per week • Per month • Occasionally>>	Quantity + Frequency+Duration				

7. PAYMENT DETAILS

Name of the Premium Payer: (if different from proposer)

Relationship with the proposer: (if different from proposer)

Premium Amount (in ₹)

Instrument type: ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Others

Please make a Crossed Cheque/DD/Pay Order in favour of 'TATA AIG General Insurance Company Limited' only.

Sources of funds: ☐ Salary ☐ Business ☐ Other_____

AML guidelines:

1. I/we hereby confirm that all premiums paid / payable in future will be 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.

2. I / we are not Politically Exposed Persons ** nor are their close relatives/family members/associates. I / we shall keep the company informed if we subsequently become a Politically Exposed Person/close relative/family member/associate of politically exposed person(s).

**"Politically Exposed Persons" shall have the meaning assigned to it under Prevention of Money-Laundering (Maintenance of Records) Amendment Rules, 2023 as amended from time to time.

Type of Organization making the payment (Please tick)

- Limited company
- Government organization
- Non-Governmental Organization (NGO)
- Society
- Trust
- Partnership
- International Organization
- Cooperatives
- Section 8 Company

Signature of Proposer & Date : …….

8. BANK DETAILS (REQUIRED FOR REFUND/CLAIMS)

As per Regulatory requirements, we can effect payment of refund / claims only through Electronic Clearing System (ECS) / National Electronics Funds Transfer (NEFT) / Real Time Gross Settlement (RTGS) / Interbank Mobile Payment Service (IMPS)

For this purpose, please submit the following details of the proposer's bank account.

Name of the account holder	
Name of the bank	
Branch Bank	
Account no.	

Bank IFSC code	
Account Type	☐ SB Account ☐ Current Account ☐ Others (please specify)

Please fill an auto debit form for deduction of amount towards premium payment from bank account.

9. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- ☐ I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorized to propose on behalf of these other persons.
- ☐ I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable.
- ☐ I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- ☐ I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- ☐ I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.
- ☐ Ayushman Bharat Health Account (ABHA) Declaration: I on behalf of all Proposed Insured Person(s) provide consent to access the medical and personal records/details [of all Proposed Insured Person(s)], as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider(s) of TATA AIG General Insurance Company Ltd and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations
- ☐ I understand that I will receive digital copy of my policy and service-related communication. However, I would prefer to also receive the physical copy of my policy and service-related communication and I want these documents to be shared via postal mail to the address as mentioned in this proposal form. For detailed terms, conditions, exclusions and policy wordings please refer our website (www.tataaig.com)

Signature of the Proposer: _____

D	D	M	M	Y	Y	Y	Y

10. DECLARATION/VERNACULAR DECLARATION/DISABILITY DECLARATION

The content of this form along with product benefits, terms/conditions and exclusions have been clearly explained to me. I/we have understood these and confirm to abide by the policy terms & conditions.

Signature of the Proposer: _____
Name & Signature of agent/intermediary with Code: _____

Disability Declaration:

(Note: The below must be witnessed by someone other than the Advisor/Intermediary/Employee of the Company)

I certify that the replies in the Proposal Form have been recorded as per the information provided by me. I, (Full name of the representative) _____ (Relationship with the Proposer) _____ ,adult and inhabitant of (City) _____ residing at _____ do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the Insurance Policy from TATA AIG General Insurance Company Ltd., to the Proposer and they have understood the same. I declare that the facts stated herein are true and correct to the best of my knowledge and belief.

Signature of the Authorized Person: _____

Name & Signature of agent/intermediary: _____

Vernacular Declaration (*Certification in case the proposer has signed in vernacular/thumb print)*
The content of this form along with product benefits, terms/conditions and exclusions have been clearly explained by me in vernacular to the proposer who has understood and confirmed the same. **Signature/Thumb impression of the Proposer: _____**
Name & Signature of agent/intermediary: _____

11. AGENT DECLARATION

I,_____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including

statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favor pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

License No.(Intermediary/Corporate Agent/Broker/Relationship Officer)													

Name of the specified Person and code

12. SECTION 41 OF INSURANCE ACT 1938 (PROHIBITION OF REBATES), as amended by Insurance Laws (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 premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to ten lakh rupees.

Section 64 VB of Insurance Act:

Commencement of the risk cover under the Policy is subject to receipt of Premium by TATA AIG General Insurance Company Limited.

13. FOR OFFICE USE ONLY

TATA AIG Office Code:

Intermediary Code and Name:

Branch Receipt Date:

Channel Type:

Business Type: Urban/ Rural/ Social

Customer ID -

TATA AIG General Insurance Company Limited.

Insurance is the subject matter of the solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale. TATA AIG General Insurance Company Limited. Registered Office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Off Senapati Bapat Road, Lower Parel, Mumbai- 400013, Maharashtra, India.

24X7 Toll Free No: 1800 266 7780 or 1800 22 9966 (For Senior Citizens)
Email:customersupport@tataaig.com Website: www.tataaig.com IRDA of India Registration No: 108
CIN: U85110MH2000PLC128425 TATA AIG MediCare Select UIN: <<>>

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14. ACKNOWLEDGEMENT (TO BE GIVEN TO CUSTOMER)

Proposal Number: _____ Date: _____

Name of the Proposer _____ _____

We acknowledge with thanks the receipt of your proposal for TATA AIG MediCare Select and amount by cheque/Demand Draft/others _____ of amount of ₹ _____. Neither the submission to us of a completed proposal for insurance nor any payment towards this application 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 to make any payment if proposal is not accepted by us or you do not accept the terms of counter offer or premium is not received by us in full and in time, or non-fulfillments of Pre-Policy Checkup and/or additional information requested by us. We shall have no liability to make any payment under the Policy if proposal is under-process & claim arises in the interim period before the decision on the proposal is given by us. In case of counter offer you need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 15 days, we shall cancel application and refund the amount paid against this proposal without interest subject to deduction of the Pre Policy Check up charges, as applicable. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 10 days subject to deduction of the Pre-Policy Check up charges, as applicable.