Portability Declaration Form

- Name of Insured MR Abishek Mittal
- 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.	Abishek Mittal	M/F	42	500000			
2.	Ruchi Mittal	M/F	39				
3.	Someha Mittal	M/F	16				
4.	Shourya Mittal	M/F	11				
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.	NO		NO	NO
2.	NO		NO	NO
3.	NO		NO	NO

- 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
	NO	NO	NO	NO

- Are you suffering from any chronic / recurring illnesses or diseases. (Refer Table B) If 'yes' Please provide the details.....NO.....
- Are you suffering from Hypertension...NO.....? 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 illeness/Disease	Waiting Period
1	Diabetes	NO
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 : Sendhwa.

Date:

Signature of the policyholder

(Name of the policy holder in full)

THE NEW INDIA ASSURANCE CO. LTD.

THE NEW INDIA ASSURANCE CO. LTD.

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

PROPOSAL FORM FOR NEW INDIA FLOATER MEDICLAIM POLICY

Please read the prospectus before filling up this form.

A. The Company shall not be on risk until the proposal has been accepted by the Company and communications of acceptance has been given to the proposer in writing on full payment of premium.

B. For persons above 50 years of age or persons below 50 years of age, having adverse medical history declared in the proposal form will have to undergo, pre-acceptance health checkup at a designated hospital/nursing home. The Divisional Office/Branch Office in the name of hospital/Nursing home will give a referral slip for conducting the pre-acceptance health checkup. The details of the check up to be done are available with the Divisional Office/Branch Office.

C. If other family members residing with proposer i.e. spouse, eligible children and eligible parents are required to be covered, complete details of each person should be furnished. Two Stamp size photograph of each person are to be submitted, one of which is to be affixed on the proposal.

D. Fresh proposal form is required along with pre acceptance medical checkup as mentioned in item (B) above, irrespective of age, when there is break in insurance cover **or** when there is request for enhancement in the sum insured.

E. **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.**

1. NAME OF PROPOSER : Mr. /Mrs. MP Abhishek Mittal
2. RESIDENTIAL ADDRESS: Maulana Azad Marg Sendhwa

Tel No: 9970011055 Fax No. _____ E-Mail: _____

3. Occupation: (please Tick)
   1) Professional/Administrative/Managerial
   2) Business /Traders
   3) Clerical, Supervisory and related workers
   4) Hospitality and Support Workers
   5) Production Workers, Skilled and non-Agricultural Laborers
   6) Farmers and Agricultural Workers
   7) Police/Para Military/Defense

4. Average Monthly Income Rs. 35000 Income Tax PAN No: _____

5. Name, Address & Tel. No of Family Physician DR GOYAL

Qualification: _____ Regn .No: _____

6. Are you at present or have you been at any other time in the past covered under any other Insurance (PA, Cancer Insurance, Hospitalization Insurance or other Medical Insurance). If so, give particulars of:

S. No.	Content	Details
1.	Name of Insurer	NO
2.	Insurance Scheme	
3.	Policy No.	
4.	Period of cover	
5.	Claim Amt. Recd./receivable	

7. Any proposal for this Insurance or any other similar insurance refused or cancelled or higher premium charged, either by us or by any other Insurer. If so, give details:

8. **DETAILS OF PERSONS TO BE INSURED:**

Sr. No:	Name of all the persons	Date of Birth	Age	Sex (M/F/T)	**Relation (*)** with the Proposer	Sum Insured selected	Occupation
1	ABISHEK MITT	6/4/1979	42	M	Self	500000	
2	RUCHI MITTAL	28/12/1982	39	F	WIFE		
3	SANCHARITA	5/4/2005	16	F	DOCTOR		
4	SHOURYA MITT	8/5/2010	11	M	SON		
5							
6.							

(*) Relation as per following table

Self	Spouse	Father
Mother	Son	Daughter
Guardian/Ward	Brother/Sister	Employer-Employee

(*)Relation as per following table

Self	Spouse	Father
Mother	Son	Daughter

9. MEDICAL HISTORY: Please answer the following questions with Yes or No (A dash is not sufficient and give full details **in respect of all the persons to be insured**)

1) Are all the members proposed for insurance in good health and free from physical and Mental disease or infirmity? If no, give details of the Illnesses / diseases for each member. **Select the Illness/conditions from the table given below:**

S. No.	Name of the Person	Nature of illness/pre-existing diseases (*)
1.		
2.		
3.		
4.		
5.		
6.		

NO

***Table for selecting Pre-Existing Disease (PED)**

Spinal or Vertebral Disorders	Cataract	Breathing Disorders
Uterine Bleeding	Arthritis and Joint disorders	Gastritis and Duodenitis
Kidney disorders	Headache Syndromes	Hernia
Stroke and T.I.A.	Any Malignancy	E.N.T. Disorders
Cholelithiasis	Ischaemic Heart Disease	Hemorrhoids
Enlargement of Prostate (BPH, enlargement of prostate)	Thyroid and Other Hormonal Disorders	Any Other (Please specify)

2) Does any of the person proposed for insurance suffer from Diabetes?

Yes ☑ No ☐

If yes, please furnish the details of the person(s) suffering from Diabetes:

S. No.	Name of the Person
1.	Abishek Mittal
2.	
3.	
4.	
5.	
6.	

3) Does any of the person proposed for insurance suffer from Hypertension?

Yes ☑ No ☐

If yes, please furnish the details of the person(s) suffering from Hypertension.

S. No.	Name of the Person
1.	
2.	
3.	
4.	
5.	
6.	

4) Have any of the persons proposed for insurance suffered from any illness/disease or had an accident in **the past six years**? If so, give details as under:

Name of the person	Nature of illness/disease/injury & treatment received	Date on which first treatment taken	First treatment completed/is continuing	Name of attending medical practitioner / surgeon with his address & tel. Nos.

Note: This information should be given for each of the persons proposed for insurance, if he/she had suffered from any illness/disease injury, please give details separately.

5) Are there any additional facts affecting the proposed Insurance, which should be disclosed to insurers? If yes, then give details below:

6) Please give details of any knowledge or any positive existence or presence of any ailment, sickness or injury, which may require medical attention? If yes, then give details below:

7) Where do you wish to take treatment? (See Table Below) : Zone I
Zone II
Zone III

EACH ZONE IS CLASSIFIED AS BELOW: (The cities mentioned below would include their Urban Agglomeration)	
Zone I	Mumbai (includes Mira-Bhayandar, Thane, Navi Mumbai, Kalyan-Dombivli, Ulhasnagar, Ambarnath, Badlapur) and state of Gujarat
Zone II	Delhi NCR (Includes Faridabad, Gurgaon, Mewat, Rohtak, Sonepat, Rewari, Jhajjhar, Panipat and Palwal, Meerut, Ghaziabad, Gautam Budha Nagar, Bulandshahr, and Baghpat, Alwar and NCT of Delhi) ,Bangalore, Chennai, Hyderabad and Secunderabad, Pune and Kolkatta
Zone III	Rest of India (other than those areas specified in Zone I and II)

8) Name of the Nominee - Ruchi Mittal Relationship Wife

9) Period of Insurance: From 4.8.22 to 3.8.23

10) Are you an employee of NIA / NIC / UIIC / OIC / GIC [ ] Yes [✓] No

If Yes, Please Furnish SR No. NO and Name of Company NO

11) **Declaration**: I declare that the persons proposed for insurance are my family members and I also declare that

(STRIKE OUT ONE OF THESE TWO STATEMENTS THAT IS NOT APPLICABLE)

i. None of them suffer from any pre-existing conditions [ ] Yes [ ] No

ii. I have given explicit information of such sickness/disease/injury sustained in the above columns where the information has been sought. [ ] Yes [ ] No

1. "I/We 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/We am/are authorized to propose on behalf of these other persons.

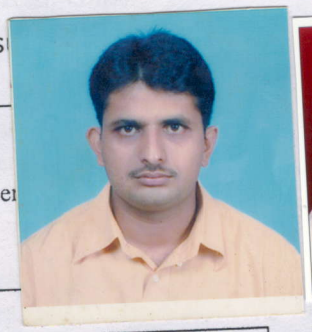
2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.

3. I/We further declare that I/we 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.

4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

5. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority."

Photographs of Ins




Proposer	1	2	3	4	5

Signature _____ _____ _____ _____ _____

Date: _____/_____/_____ Place: _____

DD MM YY

STAR Health Insurance — Personal & Caring — The Health Insurance Specialist

Star Health and Allied Insurance Company Limited

Family Health Optima Insurance Plan

SHAHLIP21211V042021

2243

In consideration of payment of Rs.15287 /- towards renewal premium of Policy number: P/201114/01/2021/005668, the policy stands renewed for a further period of 1 year as per the details given below.

Renewal Endorsement No	: **P/201114/01/2022/007565**		
		GSTIN	: 23AAJCS4517L1Z6
Customer Code	: AA0013460091		
Customer Name	: Mr.ABHISHEK MITTAL	SAC Code	: 997133/Accident and Health Insurance Services
Proposer Code	: 16368086	Issuing Office Code	: 201114
Proposer Name	: ABHISHEK MITTAL	Issuing Office Name	: Branch Office - Indore I
Address	: SENDHWA MAULANA AZAD ROAD SENDHWA, BARWANI MP Sendhwa (M),Barwani,Madhya Pradesh-451666	Address	: 101, Fortune Business Centre, 165 RNT Marg, Near Chetak Centre, Indore(MP)
Tel/Mobile	: NA/9970011055/	Tel/Mobile	: 0731- 4221130/31/32/33/34/35/36
E-mail id	:	E-mail id	: Indore.bo1@starhealth.in
Proposer GSTIN	: -	Place of Supply	: -
Proposal date	: 23/07/2020	Fulfiller Code	: SH2489
Date of Inception of first policy	: 04-AUG-2020	**Intermediary Code**	: **BA0000341750**
Renewal Year	: First Year	**Name**	: **Mr.MANMEET SINGH KARTARSHINGH RAJPAL**
Collection Number & Date	: 1158008241 & 31/07/2021	**Tel/Mobile**	: **9425087774/9425087774**
Premium	: Rs 12955 /-	**E-mail id**	: **MEETRAJPAL8@YAHOO.IN**
CGST @9% : Rs 1,166 /- SGST / UTGST @9% : Rs 1,166 /-			
Total Premium : Rs 15287 /- Stamp Duty : Re 1 /-			

Total Premium In Words : **Rupees Fifteen Thousand Two Hundred Eighty Seven Only**

Installment Facility Optn :No	Premium Payment Frequency :Annual	Installment Amount Rs. : 0

Period of insurance : **From :** 04/08/2021 00:00 **To :** Midnight of 03/08/2022

Basic Floater Sum Insured : 500000 **Scheme Description :** 2A+2C

In words : Rupees: Five Lakhs Only

Bonus: Rs. 125000 **Limit of Coverage : Rs.** 625000 **Recharge Benefit :** Rs. 150000

Details of Insured Persons :

Sl. No.	Name of the Insured	Gender	Date of Birth	Age in Yrs	Relationship with Proposer	ID Card No	Pre Existing Disease	Inception Date
1	ABHISHEK MITTAL	M	06/04/1979	42	SELF	16368086-1	No PED declared	04/08/2015
2	RUCHI MITTAL	F	28/02/1982	39	SPOUSE	16368086-2	No PED declared	04/08/2015
3	SNEHA MITTAL	F	05/04/2005	16	DEPENDANT CHILD	16368086-3	No PED declared	04/08/2015
4	SHOURYA MITTAL	M	08/05/2010	11	DEPENDANT CHILD	16368086-4	No PED declared	04/08/2015

Entered By : PREMIA

Approved By : BACKDATE

For Star Health and Allied Insurance Company Ltd.

Health and Allied Ins. Co. Ltd. INDORE

INSURANCE

Authorised Signatory

IRDAI Regn. No 129

Corporate Identity Number U66010TN2005PLC056649

Email ID : support@starhealth.in

Star Health and Allied Insurance Company Limited

STAR Health Insurance
Personal & Caring
The Health Insurance Specialist

Attached to and forming part of Policy No. P/201114/01/2022/007565

Nominee Details

Nominee Details for the proposer					Appointee Details		
S.No.	Name	Relationship with proposer	Age	% of the claim	Appointee Name	Age	Relationship with Nominee
1	RUCHI MITTAL	Spouse	39	100			

Sector Classification

Urban		

Please check whether the details given by you about the insured persons in the proposal form are incorporated correctly in the policy schedule. If you find any discrepancy, please inform us within 15 days from the date of receipt of the policy, failing which the details relating to the insured person given in the policy schedule are deemed to have been accepted by you.

Warranted that in case of dishonor of premium cheque(s), the Company shall not be liable under the policy and the policy shall be void abinitio (from inception).

Condition No. 3 regarding delay in payment of claim shall read as follows and not as stated in policy wordings:
"The Company shall pay interest as per Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017, in case of delay in payment of an admitted claim under the Policy"
Condition No: 13 of the policy wordings should read as follows
"Automatic Termination: The insurance under this policy shall terminate immediately on the earlier of the following events:
* Upon the death of the Insured Person This means that, the cover for the surviving members of the family will continue, subject to other terms of the policy.
* Upon exhaustion of the Basic Sum Insured, Basic Sum Insured plus Bonus, Basic Sum Insured plus Bonus plus Restore and / or Recharge Sum Insured."

Important

In the event of hospitalization of insured person, intimation should be given to the Company immediately, however, within 24 hrs from the time of admission.

Toll Free No : 1800 425 2255 / 1800 102 4477 Email: support@starhealth.in, Fax No: 1800 425 5522 .

AYUSH Hospital means a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

1. Central or State Government AYUSH Hospital or
2. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine/Central Council for Homeopathy; or
3. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
   i. Having at least 5 in-patient beds;
   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
   iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iv. Maintaining daily records of the patients and making them accessible to the insurance Company's authorized representative.

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Entered By : PREMIA
Approved By : BACKDATE

For Star Health and Allied Insurance Company Ltd.

Star Health and Allied Ins. Co. Ltd. INDORE 1

Authorised Signatory

STAR Health Insurance
Personal & Caring
The Health Insurance Specialist

Star Health and Allied Insurance Company Limite

Family Health Optima Insurance Plan

1377

Unique Identification No. IRDAI/HLT/SHAI/P-H/V.III/129/2017-18

Policy Schedule

Policy No.	: **P/201114/01/2021/005668**	**Previous Policy No.**	: **45170134192800000050**
Customer Code	: AA0013460091	GSTIN	: 23AAJCS4517L1Z6
Customer Name	: Mr.ABHISHEK MITTAL	SAC Code	: 997133/Accident and Health Insurance Services
Proposer Code	: 16368086	Issuing Office Code	: 201114
Proposer Name	: ABHISHEK MITTAL	Issuing Office Name	: Branch Office - Indore I
Address	: SENDHWA MAULANA AZAD ROAD SENDHWA, BARWANI MP Sendhwa (M),Barwani,Madhya Pradesh-451666	Address	: 207, Shalimar Corporate Centre , 8-B South Tukoganj, Indore, Madhya Pradesh - 452 001.
Tel/Mobile	: NA/9970011055/	Tel/Mobile	: 0731- 4221130/31/32/33/34/35/36
E-mail id	:	E-mail id	: Indore.bo1@starhealth.in
Proposer GSTIN	: -	Place of Supply	: -
Proposal date	: 23/07/2020	Fulfiller Code	: SH2489
Date of Inception of first policy	: 04-AUG-20	**Intermediary Code**	: **BA0000341750**
Renewal Year	: NEW	**Name**	: **Mr.MANMEET SINGH KARTARSHINGH RAJPAL**
Collection Number & Date	: 1158006109 & 23/07/2020	**Tel/Mobile**	: **9425087774/9425087774**
Premium : Rs 12955 /- CGST @9% : Rs 1,166 /- SGST / UTGST @9% : Rs 1,166 /- Total Premium : Rs 15287 /- Stamp Duty : Re 1 /-		**E-mail id**	: **MEETRAJPAL8@YAHOO.IN**

Total Premium In Words : Rupees Fifteen Thousand Two Hundred Eighty Seven Only

Period of insurance : **From :** 04/08/2020 00:00:00 **To :** Midnight of 03/08/2021

Basic Floater Sum Insured : 500000 **Scheme Description :** 2A+2C

In words : Rupees: Five Lakhs Only

Bonus: Rs. 0 **Limit of Coverage : Rs.** 500000 **Recharge Benefit :** Rs. 150000

Details of Insured Persons :

Sl. No.	Name of the Insured	Gender	Date of Birth	Age in Yrs	Relationship with Proposer	ID Card No	Pre-existing Disease	Inception Date
1	ABHISHEK MITTAL	M	06/04/1979	41	SELF	16368086-1	No PED declared	04/08/2015
2	RUCHI MITTAL	F	28/02/1982	38	SPOUSE	16368086-2	No PED declared	04/08/2015
3	SNEH MITTAL	F	05/04/2005	15	DEPENDANT CHILD	16368086-3	No PED declared	04/08/2015
4	SHOURYA MITTAL	M	08/05/2010	10	DEPENDANT CHILD	16368086-4	No PED declared	04/08/2015

Entered By : SH10587

For Star Health and Allied Insurance Comp

IRDAI Regn. No 129

Corporate Identity Number U66010TN2005PLC056649

Email ID : support@starhealth.in

Star Health and Allied Ins. Co. Ltd INDORE INSURANCE

Authorised Signatory

Attached to and forming part of Policy No. P/201114/01/2021/005668

Nominee Details

Nominee Details for the proposer					Appointee Details		
S.No.	Name	Relationship with proposer	Age	% of the claim	Appointee Name	Age	Relationship with Nominee
1	RUCHI MITTAL	Spouse	38	100			

Sector Classification

Urban		

Please check whether the details given by you about the insured persons in the proposal form are incorporated correctly in the policy schedule. If you find any discrepancy, please inform us within 15 days from the date of receipt of the policy, failing which the details relating to the insured person given in the policy schedule are deemed to have been accepted by you.

Warranted that in case of dishonor of premium cheque(s), the Company shall not be liable under the policy and the policy shall be void abinitio (from inception).

Condition No. 3 regarding delay in payment of claim shall read as follows and not as stated in policy wordings:
"The Company shall pay interest as per Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017, in case of delay in payment of an admitted claim under the Policy"

THE INSURANCE UNDER THIS POLICY IS SUBJECT TO CONDITIONS, CLAUSES, WARRANTIES, EXCLUSIONS ETC., ATTACHED.

Condition No: 13 of the policy wordings should read as follows
"Automatic Termination: The insurance under this policy shall terminate immediately on the earlier of the following events:
* Upon the death of the Insured Person This means that, the cover for the surviving members of the family will continue, subject to other terms of the policy.
* Upon exhaustion of the Basic Sum Insured, Basic Sum Insured plus Bonus, Basic Sum Insured plus Bonus plus Restore and / or Recharge Sum Insured."

Important

In the event of hospitalization of insured person, intimation should be given to the Company immediately, however, within 24 hrs from the time of admission.

Toll Free No : 1800 425 2255 / 1800 102 4477 Email: support@starhealth.in, Fax No: 1800 425 5522 .

Continuity Benefits applicable is as follows

S.No.	Name Of the Insured	Id card No	30 Days Waiting Period	1st Year Exclusions	First Two Year Exclusion	Pre Existing Disease
1	ABHISHEK MITTAL	16368086-1	Waived	Not Applicable	Waived	Covered
2	RUCHI MITTAL	16368086-2	Waived	Not Applicable	Waived	Covered
3	SNEH MITTAL	16368086-3	Waived	Not Applicable	Waived	Covered
4	SHOURYA MITTAL	16368086-4	Waived	Not Applicable	Waived	Covered

"A waiting period apply as fresh from the date of enhancement for the increase in the sum insured, that is, the difference between the expiring policy sum insured and the increased current sum insured".

In witness whereof the undersigned being authorized by and on behalf of the company has set his hand at Branch Office - Indore I on 23rd Day of July 2020.

Entered By : SH10587

For Star Health and Allied Insurance Company Ltd.

Star Health and Allied Ins. Co. Ltd. INDORE I

Authorised Signatory

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

THE NEW INDIA ASSURANCE CO. LTD.
REGISTERED & HEAD OFFICE:87,MAHATMA GANDHI ROAD,MUMBAI
400001

Customer ID	:	PO35871212

NEW INDIA FLOATER MEDICLAIM SCHEDULE

Insureds Details			**Issuing Office Details**		
Insured Name	:	MR. ABHISHEK MITTAL	**Office Code**	:	SENDHWA BRANCH (451701)
Address	:	MOLANA AZAD MARG SENDHWA DISTT BARWANI SENDHWA (KHARGON) ,MADHYA PRADESH, 451666	**Address**	:	OPPOSITE VETERINARY HOSPITAL A.B ROAD ,451666
Phone No/Mobile No.	:	9970011055	**Phone No**	:	07281222302 / 07281224302
E-mail/Fax	:	/	**E-mail/Fax**	:	nia.451701@newindia.co.in / 07281222302
PAN No	:		**S.Tax Regn. No**	:	AAACN4165CST178
GSTIN/UIN	:	NA / NA	**GSTIN**	:	23AAACN4165C1ZZ
	:		**SAC**	:	997139 (Other non-life insurance services excl RI)

Policy Details					
			Business Source Code		
Policy Number	:	45170134192800000050	**Dev.Off level./Broker/Direct/Web Aggregator**	:	DIRECT BUSINESS (2D10673460)
Period of Insurance	:	From:04/08/2019 12:00:01 AM To:03/08/2020 11:59:59 PM	**Agent/Bancassurance/Specified Person**	:	Mrs. SUKHMEET KAUR RAJPAL (AG00037533)
Prev. Policy no.	:	45170134182800000074	**Phone No**	:	9425326922, 9926987774 / 07281222302, 07281224302,
Client Type	:	Non-Corporate	**E-mail/Fax**	:	sukh.meet1977@yahoo.com / nia.451701@newindia.co.in, / 07281228282 / 07281222302

Member Details							
Sl. No.	Name of Insured Person	Date of Birth	Sex	Occupation	Relation	Date of inception of Continuous Coverage	Pre-Existing Disease
1	SMT. RUCHI W/O ABHISHEK MITTAL	28/02/1982	M	Housewife	Spouse	04/08/2015	Not Applicable
2	MISS. SNEHA D/O ABHISHEK MITTAL	05/04/2005	M	Students - School and College	Children	04/08/2015	Not Applicable
3	MASTER SHOURYA S/O ABHISHEK MITTAL	08/05/2010	M	Any Other	Children	04/08/2015	Not Applicable
4	MR. ABHISHEK MITTAL	06/01/1979	M	Business / Traders	Self	04/08/2015	Not Applicable

Total Sum Insured	500000

Signature Not Verified
Digitally signed by Srinivasan Vaideswaran
Date: 2019.07.31 16:15:25 IST

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

Details Of TPA(Notice or communication to be given in respect of claims)					
Name	:	MDINDIA HEALTH INSURANCE TPA PVT. LIMITED	**Telephone**	:	02025300000
Address	:	S. NO. 46/1, E-SPACE, A-2 BUILDING, 3RD FLOOR, PUNE-NAGAR ROAD, VADGAONSHERI, PUNE-411014 NA	**Fax** **Email** **Toll Free No.** **Mobile No.**	: : : :	02025300003

Name of Nominee :	SMT.RUCHI MITTAL	**Relation :**	Spouse

Premium Working Table

Sl. No.	Name of Insured	Total Basic Premium	Family Discount	Gross Premium
1	SMT. RUCHI W/O ABHISHEK MITTAL	5166	775	4391
2	MISS. SNEHA D/O ABHISHEK MITTAL	2079	312	1767
3	MASTER SHOURYA S/O ABHISHEK MITTAL	2079	312	1767
4	MR. ABHISHEK MITTAL	5166	775	4391
			Total Gross Premium	12316

GST	2216
Net Premium Amt.	14532
Net Premium Amt.(In words)	RUPEES FOURTEEN THOUSAND FIVE HUNDRED THIRTY-TWO ONLY

*This Policy is subject to terms and conditions of New India Floater Mediclaim.

Premium and GST Details

	Rate of Tax	Amount in INR
Premium		₹12316
SGST	9	1108
CGST	9	1108
IGST	0	0

IN WITNESS WHEREOF,the undersigned being duly authorized has hereunto set his/her hand

at _____ this _____ day of _____ 20

Date of Issue: 31/07/2019

(Mr. Madanlal Raniwal)
[Branch Manager]
Authorized Signatory For and on behalf of
The New India Assurance Company
Limited

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

Insurer Office Code	:	SENDHWA BRANCH (451701)
Address	:	OPPOSITE VETERINARY HOSPITAL A.B ROAD ,451666
Telephone	:	07281222302 / 07281224302
Fax	:	07281222302

New India Floater Mediclaim

PREMIUM CERTIFICATE FOR THE PURPOSE OF DEDUCTION UNDER SECTION 80 D OF INCOME TAX (AMENDMENT) ACT 1986

This is to certify that Mr./Mrs. MR. ABHISHEK MITTAL has paid ₹ RUPEES FOURTEEN THOUSAND FIVE HUNDRED THIRTY-TWO ONLY (in words) towards premium for New India Floater Mediclaim for the period 04/08/2019 12:00:01 AM to 03/08/2020 11:59:59 PM

Policy no.	:	45170134192800000050
Receipt no. & date	:	45170181190000002508 31/07/2019

Date of Issue: 31/07/2019

(Mr. Madanlal Raniwal)
[Branch Manager]
Authorized Signatory For and on behalf of
The New India Assurance Company
Limited

(Note: This certificate must be surrendered to the Insurance Company for issuance of fresh certificate in case of cancellation of the policy or any alteration in the Insurance affecting the premium)

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

THE NEW INDIA ASSURANCE CO. LTD.
REGISTERED & HEAD OFFICE:87,MAHATMA GANDHI ROAD,MUMBAI
400001

Customer ID	:	PO35871212

NEW INDIA FLOATER MEDICLAIM SCHEDULE

Insureds Details			Issuing Office Details		
Insured Name	:	MR. ABHISHEK MITTAL	Office Code	:	SENDHWA BRANCH (451701)
Address	:	MOLANA AZAD MARG SENDHWA DISTT BARWANI SENDHWA (KHARGON) ,MADHYA PRADESH, 451666	Address	:	OPP. VETERINARY HOSPITAL, A.B.ROAD, ,451666
Phone No/Mobile No.	:		Phone No	:	07281222302 / 07281224302
E-mail/Fax	:	/	E-mail/Fax	:	nia.451701@newindia.co.in / 07281222302
PAN No	:		S.Tax Regn. No	:	AAACN4165CST178
GSTIN/UIN	:	NA / NA	GSTIN	:	23AAACN4165C1ZZ
	:		SAC	:	997139 (Other non-life insurance services excl RI)

Policy Details			Business Source Code		
Policy Number	:	45170134182800000074	Dev.Off level./Broker/Direct	:	DIRECT BUSINESS (2D10673460)
Period of Insurance	:	From:04/08/2018 12:00:01 AM To:03/08/2019 11:59:59 PM	Agent/Bancassurance	:	Mrs. SUKHMEET KAUR RAJPAL (AG00037533)
Prev. Policy no.	:	45170134162800000085	Phone No	:	9425326922, 9926987774 / 07281222302, 07281224302,
Client Type	:	Non-Corporate	E-mail/Fax	:	sukh.meet1977@yahoo.com / nia.451701@newindia.co.in, / 07281228282 / 07281222302

Member Details

Sl. No.	Name of Insured Person	Date of Birth	Sex	Occupation	Relation	Date of inception of Continuous Coverage	Pre-Existing Disease
1	MR. ABHISHEK MITTAL	06/01/1979	M	Business / Traders	Self	04/08/2015	Not Applicable
2	SMT. RUCHI W/O ABHISHEK MITTAL	28/02/1982	M	Housewife	Spouse	04/08/2015	Not Applicable
3	MISS. SNEHA D/O ABHISHEK MITTAL	05/04/2005	M	Students - School and College	Children	04/08/2015	Not Applicable
4	MASTER SHOURYA S/O ABHISHEK MITTAL	08/05/2010	M	Any Other	Children	04/08/2015	Not Applicable

Total Sum Insured	500000

Details Of TPA(Notice or communication to be given in respect of claims)

Signature Not Verified
Digitally signed by Srinivasan Vaideswaran
Date: 2018.08.02 12:25:34 IST

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

Name	:	MDINDIA HEALTH INSURANCE TPA PVT. LIMITED	**Telephone**	:	02025300000
Address	:	S. NO. 46/1, E-SPACE, A-2 BUILDING, 3RD FLOOR, PUNE-NAGAR ROAD, VADGAONSHERI, PUNE-411014 NA	**Fax** **Email** **Toll Free No.** **Mobile No.**	: : : :	02025300003

Name of Nominee :	SMT.JYOTI MITTAL R.P.NO.32170048148565000200	**Relation :**	Spouse

Premium Working Table

Sl. No.	Name of Insured	Total Basic Premium	Family Discount	Gross Premium
1	SMT. RUCHI W/O ABHISHEK MITTAL	5166	775	4391
2	MISS. SNEHA D/O ABHISHEK MITTAL	2079	312	1767
3	MASTER SHOURYA S/O ABHISHEK MITTAL	2079	312	1767
4	MR. ABHISHEK MITTAL	5166	775	4391
			Total Gross Premium	12316

GST	2216
Net Premium Amt.	14532
Net Premium Amt.(In words)	RUPEES FOURTEEN THOUSAND FIVE HUNDRED THIRTY-TWO ONLY

*This Policy is subject to terms and conditions of New India Floater Mediclaim.

Premium and GST Details

	Rate of Tax	Amount in INR
Premium		₹12316
SGST	9	1108
CGST	9	1108
IGST	0	0

IN WITNESS WHEREOF,the undersigned being duly authorized has hereunto set his/her hand

at _____ this _____ day of _____ 20

Date of Issue: 02/08/2018

Authorized Signatory For and on behalf of
The New India Assurance Company Limited

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

Insurer Office Code	:	SENDHWA BRANCH (451701)
Address	:	OPP. VETERINARY HOSPITAL, A.B.ROAD, ,451666
Telephone	:	07281222302 / 07281224302
Fax	:	07281222302

New India Floater Mediclaim

PREMIUM CERTIFICATE FOR THE PURPOSE OF DEDUCTION UNDER SECTION 80 D OF INCOME TAX (AMENDMENT) ACT 1986

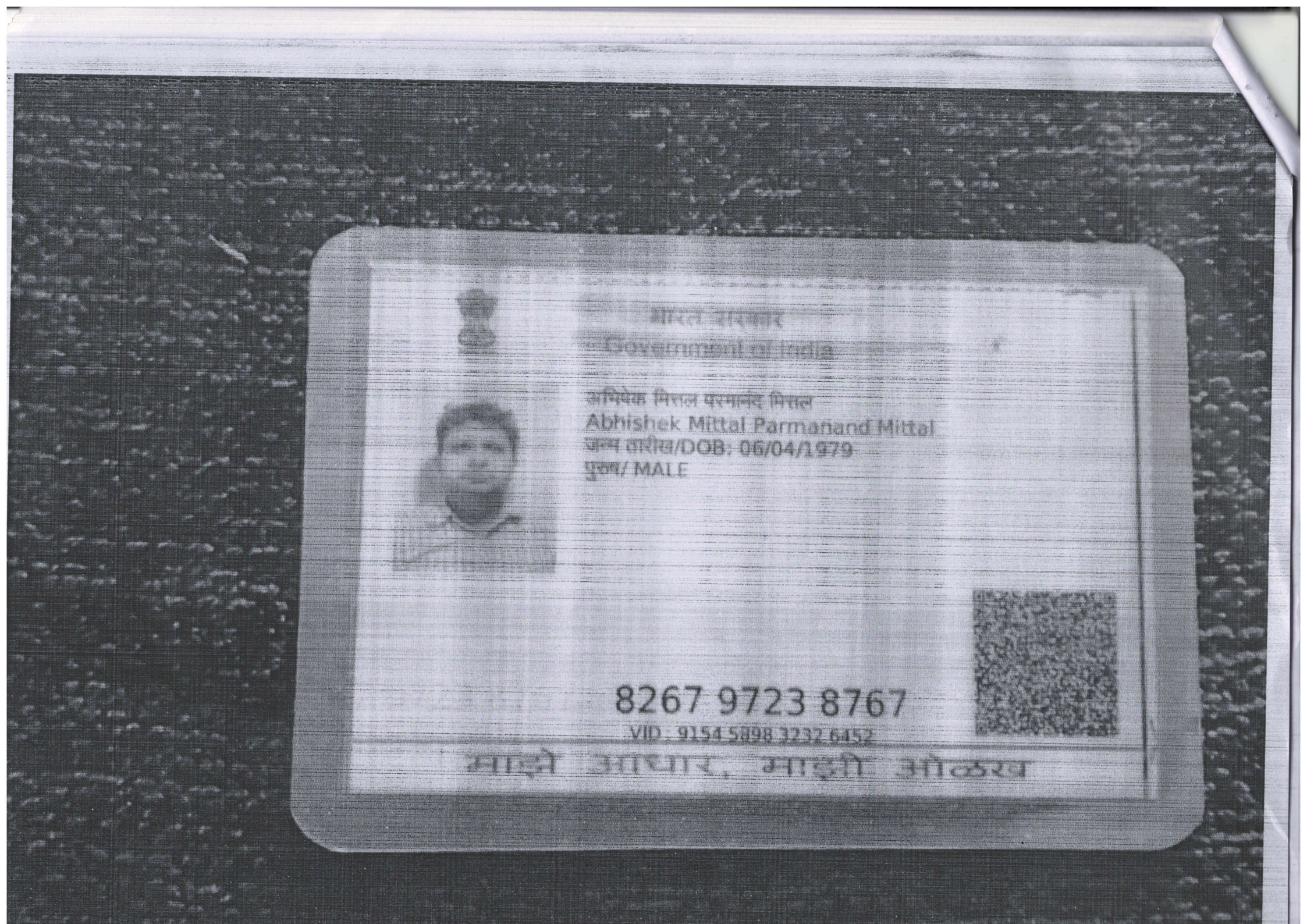
This is to certify that Mr./Mrs. MR. ABHISHEK MITTAL has paid ₹ RUPEES FOURTEEN THOUSAND FIVE HUNDRED THIRTY-TWO ONLY (in words) towards premium for New India Floater Mediclaim for the period 04/08/2018 12:00:01 AM to 03/08/2019 11:59:59 PM

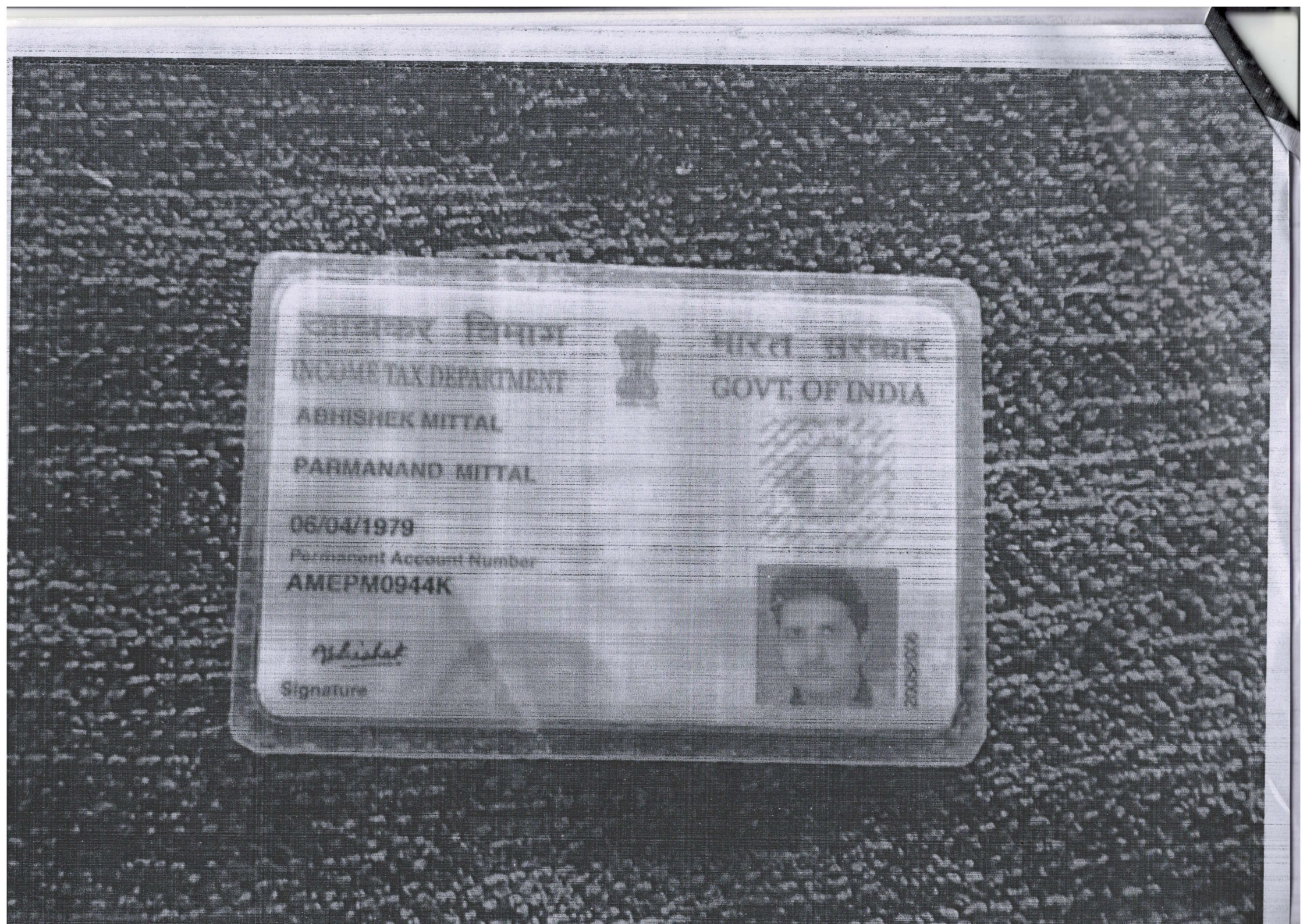
Policy no.	:	45170134182800000074
Receipt no. & date	:	45170181180000002263 02/08/2018

Date of Issue: 02/08/2018

Authorized Signatory For and on behalf of
The New India Assurance Company
Limited

(Note: This certificate must be surrendered to the Insurance Company for issuance of fresh certificate in case of cancellation of the policy or any alteration in the Insurance affecting the premium)


भारत सरकार
Government of India
अभिषेक मित्तल परमानंद मित्तल
Abhishek Mittal Parmanand Mittal
जन्म तारीख/DOB: 06/04/1979
पुरुष/ MALE
8267 9723 8767
VID : 9154 5898 3232 6452
मेरा आधार, मेरी पहचान


INCOME TAX DEPARTMENT
GOVT. OF INDIA
ABHISHEK MITTAL
PARMANAND MITTAL
06/04/1979
Permanent Account Number
AMEPM0944K
Signature

भारत सरकार

GOVERNMENT OF INDIA

रूचि मित्तल

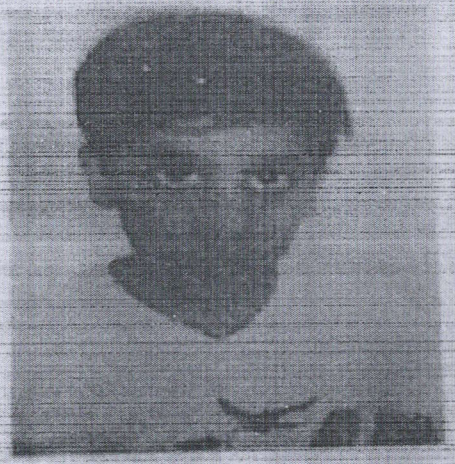
Ruchi Mittal

जन्म तिथि/ DOB: 28/02/1982

महिला / FEMALE

3172 1758 8408

आधार-आम आदमी का अधिकार



शौर्य मित्तल

Shourya Mittal

जन्म तिथि/ DOB: 08/05/2010

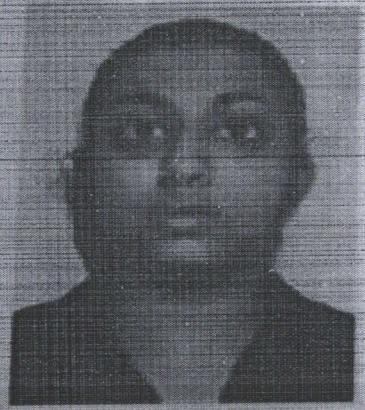
पुरुष / MALE

2679 1451 0777

आधार -आम आदमी का अधिकार

भारत सरकार
Government of India

आधार



स्नेहा अभिषेक मित्तल
Sneha Abhishek Mittal
जन्म तिथि/DOB: 05/04/2005
महिला/ FEMALE

Issue Date: 04/01/2014

2608 1032 1909

VID : 9115 9935 4515 1139

मेरा आधार, मेरी पहचान