

**PROPOSAL FORM**  
**GROUP MEDICLAIM INSURANCE CUM PERSONAL ACCIDENT**  
**FOR CANARA BANK ACCOUNT HOLDERS**

<p><b>1. NAME &amp; ADDRESS OF THE ACCOUNT HOLDER (in CAPITAL letters)</b></p>  <p><b>2. SUM INSURED PER FAMILY Please ( ) :</b></p> <table style="width:100%; text-align: center;"> <tr> <td>Rs.50,000</td> <td>Rs.1 Lac</td> <td>Rs.1.5 Lac</td> <td>Rs.2 Lac</td> <td>Rs.2.5 Lac</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>Rs.3 Lac</td> <td>Rs.3.5 Lac</td> <td>Rs.4 Lac</td> <td>Rs.4.5 Lac</td> <td>Rs.5 Lac</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	Rs.50,000	Rs.1 Lac	Rs.1.5 Lac	Rs.2 Lac	Rs.2.5 Lac	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Rs.3 Lac	Rs.3.5 Lac	Rs.4 Lac	Rs.4.5 Lac	Rs.5 Lac	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<p align="center">(To be filled by the Bank)</p> <p><b>3 a. Branch Name</b></p> <p>b. DP Code <input style="width: 40px;" type="text"/></p> <p>b. City <input style="width: 40px;" type="text"/></p> <p>c. Proposal from (Pl. Tick) Rural/Semi Urban/Urban</p> <p><b>4. Account No.....</b> <b>SB/CA/FD/others (Pl. specify)</b></p>
Rs.50,000	Rs.1 Lac	Rs.1.5 Lac	Rs.2 Lac	Rs.2.5 Lac																	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>																	
Rs.3 Lac	Rs.3.5 Lac	Rs.4 Lac	Rs.4.5 Lac	Rs.5 Lac																	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>																	

**5. DETAILS OF PERSONS TO BE COVERED :**

SLNO	NAME OF THE INSURED PERSON (in CAPITAL letters)	AGE (yrs)	SEX	RELATIONSHIP	EXISTING DISEASE / ILLNESS / INJURY*
I					
II					
III					
IV					
V					
VI					

\*Additional sheets may be used wherever required.

**6. Period of Insurance:** One year from the date of Policy

**7. TWO STAMP-SIZE PHOTOGRAPH OF THE INSURED PERSONS :**

ACCOUNT HOLDER	SPOUSE	CHILD 1	CHILD 2	PARENT 1	PARENT 2
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**8. NAME OF THE T.P.A :** [ ] M/S. TTK HEALTH SERVICES PVT. LTD., [ ] M/S. MEDIASSIST HEALTH SERVICES PVT.LTD. [ ] M/S. E-MEDITEK SOLUTIONS LTD.

9.I hereby declare and agree that the above statements are true and complete. Myself and family members are maintaining good health subject to existing diseases/illness/injury as per Serial No.5 above. I have read the salient features of the policy and willing to accept the cover subject to the terms, conditions and exceptions prescribed by the Insurance Company. Enclose copy of existing medical insurance of cardholder or other family members.

I/We agree that Canara Bank is no way responsible for claims under Canara Mediclaim and same have to be pursued with the particular T.P.A. / Insurance Company.

**PLACE** .....

**DATE** .....

**SIGNATURE OF THE PROPOSER**

This is to certify that Sri/Smt .....(Name of the account holder) is maintaining account with the bank ,bearing No. ....(Account number).

**SEAL OF THE BRANCH**

**SIGNATURE OF BRANCH MANAGER**

**PREMIUM CHART - PLAN A (Family size: 1+3) inclusive of service tax @ 12.36%**

Sum insured	0.50 lacs	1.00 lacs	1.50 lacs	2.00 lacs	2.50 lacs	3.00 lacs	3.50 lacs	4.00 lacs	4.50 lacs	5.00 lacs
Premium	956	1848	2709	3488	4181	4875	5484	6094	6706	7316

**PREMIUM CHART - PLAN B (Family size: 1+5) inclusive of service tax @ 12.36%**

Sum insured	0.50 lacs	1.00 lacs	1.50 lacs	2.00 lacs	2.50 lacs	3.00 lacs	3.50 lacs	4.00 lacs	4.50 lacs	5.00 lacs
Premium	1597	3085	4519	5815	6967	8120	9131	10143	11156	12167

**Note: DD to be made in favour of United India Insurance Co.Ltd**