Proposal Form

URN : CHIL / R / HE / 082 / 22-23

Proposal No.:_____

1. To be filled in by the Proposer in CAPITAL LETTERS only.
2. Care Health Insurance Limited (the "Company") is under no obligation to accept any proposal for insurance and to issue a policy by the mere submission of a completed proposal form or due to any payment for any policy. In the event the Company does not accept the proposal, You will be informed of the same and the premium received (less costs of medical tests) from You, if any, will be refunded without interest.
3. If there is insufficient space for You to complete Your answers, please use the Additional Information section. All attached documents form part of this Proposal Form.
4. The proposed policyholder will be referred to in this Proposal Form as "Proposer", "You" or "Your".

FOR OFFICE USE ONLY

Intermediary Details

Intermediary Code :		Intermediary Name :	
Intermediary RM Code :		Branch Code :	
Customer Acc No. :			

Care Health Insurance Branch Details

CHI RM Name :			
Branch Code :		Client ID :	Receipt ID :

Details of 'Point of Sales' Person : (To be filled in if the Policy is sourced through 'Point of Sales' Person)

Please furnish at least one of the following details of "Point of Sales" Person:	
Aadhaar Card No.:	PAN Card No.:

PROPOSER DETAILS

Name : (Mr./Ms./Mrs.)			
	(First Name)	(Middle Name)	(Last Name)
Correspondence Address :			
Locality :		City :	
Pin Code :		State :	
Landmark :			
Permanent Address : If same as above, please tick here ☐			
Locality :		City :	
Pin Code :		State :	
Telephone :		Mobile* :	
Alternate No. :			
Email :			

*The registered mobile number will be enrolled for WhatsApp notifications related to your Care Health Insurance Policy

Date of Birth / Incorporation (in case Proposer is an entity) : D D M M Y Y Y Y Gender : Male ☐ Female ☐ Others ☐

Marital Status : Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated ☐

Mother's Name :			
PAN Number :		Nationality :	
Form 60 (only in case the customer does not have PAN no.) :	☐ Yes ☐ No	Aadhaar Number(last 4 digits):	X X X X X X X X

(By signing the Proposal form I give my consent for using my Aadhaar No. for Authentication of my Aadhaar Details)

Please share the following for authentication purpose:

Proof of Identity (POI) (☑ Tick whichever is applicable)

PAN ☐ Aadhaar ☐ Passport ☐ Driving License ☐ Voter ID Card ☐

Letter from a recognized public authority or public servant verifying the identity and residence of the Proposer ☐

Proof of Address (POA) (☑ Tick whichever is applicable)

Electricity bill (not older than 3 months) ☐ Aadhaar ☐ Passport ☐ Ration Card ☐ Driving License ☐

Telephone Bill (not older than 3 months) ☐ Bank Account Statement (not older than 3 months) ☐

Letter from a recognized public authority or public servant verifying the identity and residence of the Proposer ☐

Care Health Insurance Limited
Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019 Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road, Sector-43, Gurugram-122009 (Haryana) Website: www.careinsurance.com CIN: U66000DL2007PLC161503 UIN: RHIHLIP21371V022021 IRDAI Registration No. - 148

Would you like to opt for Electronic Policy Issuance through an e-Insurance Account (eIA) of an Insurance Repository? ☐ Yes ☐ No

If you have an eIA, please provide following details:

I) Name of Insurance Repository:	
ii) eIA No:	
iii) Name as appearing in eIA:	

If you do not have an eIA, would you like to open an account? ☐ Yes ☐ No

If Yes, choose any one Insurance Repository:

☐ CAMSRep- CAMS Repository Services Limited	☐ NDML – NSDL Data Management Limited
☐ SHCIL – Stock Holding Corporation of India Limited	☐ Karvy Insurance Repository Limited
☐ CIRL-Central Insurance Repository Limited (CDSL)	

Help us preserve the environment by opting to receive policy related information in soft copy/via email only: ☐ Yes ☐ No

POLICY DETAILS

Plan Opted:			
Sum Insured (in Rs.):		Tenure:	1 Year ☐ 2 Year ☐ 3 Year ☐
Deductible (in Rs.):			Co-payment (in %):
Cover Type:	Individual ☐ Floater ☐		
Optional Benefit – 1 : OPD Care	Yes ☐ No ☐		
(If Yes, then please mention the per consultation payable claim limit (in Rs.):			
Optional Benefit – 2 : International Second Opinion	Yes ☐ No ☐		
Optional Benefit – 3 : Home Care	Yes ☐ No ☐		
Optional Benefit – 4 : Active Health Check-up	Yes ☐ No ☐		
Are you applying for portability?	Yes ☐ No ☐	(If yes, please fill in the separate Portability Form)	

NOMINEE DETAILS

Nominee Name	Date of Birth (DD/MM/YYYY)	Relationship with Proposer

*If the Nominee is of Age 18 years or less, Name of Appointee and Relationship with Minor:

Appointee Name	Date of Birth (DD/MM/YYYY)	Relationship with Minor

In event of the death of the Proposer any payment due under the Policy shall become payable to the Nominee proposed in this Proposal Form. The receipt of the proceeds by the Nominee would be sufficient discharge of the Company. The Nominee for all the other person(s) proposed to be insured shall be the Proposer himself.

DETAILS OF THE PROPOSED TO BE INSURED INCLUDING PROPOSER

Insured 1 : Name : Mr./Ms./Mrs.						
Height	cms	Marital Status		Date of Birth D D M M Y Y Y Y	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male ☐ Female ☐ Others ☐		Aadhaar/PAN No.(Optional)	
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	If PEP* :	Yes ☐ No ☐
Do you have ABHA No.	Yes ☐ No ☐	If Yes, please provide ABHA Number (Optional)				
Insured 2 : Name : Mr./Ms./Mrs.						
Height	cms	Marital Status		Date of Birth D D M M Y Y Y Y	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male ☐ Female ☐ Others ☐		Aadhaar/PAN No.(Optional)	
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	If PEP* :	Yes ☐ No ☐
Do you have ABHA No.	Yes ☐ No ☐	If Yes, please provide ABHA Number (Optional)				
Insured 3 : Name : Mr./Ms./Mrs.						
Height	cms	Marital Status		Date of Birth D D M M Y Y Y Y	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male ☐ Female ☐ Others ☐		Aadhaar/PAN No.(Optional)	
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	If PEP* :	Yes ☐ No ☐
Do you have ABHA No.	Yes ☐ No ☐	If Yes, please provide ABHA Number (Optional)				
Insured 4 : Name : Mr./Ms./Mrs.						
Height	cms	Marital Status		Date of Birth D D M M Y Y Y Y	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male ☐ Female ☐ Others ☐		Aadhaar/PAN No.(Optional)	
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	If PEP* :	Yes ☐ No ☐
Do you have ABHA No.	Yes ☐ No ☐	If Yes, please provide ABHA Number (Optional)				
Insured 5 : Name : Mr./Ms./Mrs.						
Height	cms	Marital Status		Date of Birth D D M M Y Y Y Y	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male ☐ Female ☐ Others ☐		Aadhaar/PAN No.(Optional)	
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	If PEP* :	Yes ☐ No ☐
Do you have ABHA No.	Yes ☐ No ☐	If Yes, please provide ABHA Number (Optional)				

Insured 6 : Name : Mr./Ms./Mrs.				
Height cms	Marital Status	Date of Birth DDMMYYYY	Annual Income (In Lacs) : ₹	
Weight kg	Gender Male ☐ Female ☐ Others ☐	Aadhaar/PAN No.(Optional)		
Nominee (Relationship with Insured) :	Relationship with Proposer :	City of Residence :	If PEP* : Yes ☐ No ☐	
Do you have ABHA No. Yes ☐ No ☐	If Yes, please provide ABHA Number (Optional)			

*Have you ever been entrusted with prominent public functions, forexample, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations or important political party officials.

MEDICAL / LIFESTYLE RELATED INFORMATION

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Does any proposed insured currently or in past Diagnosed/Suffered/Treated/Taken Medication for any of the following conditions: **If yes, please provide details in the additional information section below:**						
1. Have you ever been diagnosed for any cardiac ailment /disorder?	Y N Since______	Y N Since______	Y N Since______	Y N Since______	Y N Since______	Y N Since______
2. Have you undergone any procedure or surgery for any cardiac ailment?	Y N Since______	Y N Since______	Y N Since______	Y N Since______	Y N Since______	Y N Since______
3. Please specify the type of cardiac ailment you have been operated for PTCA (Angioplasty) / CABG / Septal defect surgery(ASD/VSD) / Radiofrequency ablation (RFA) / Others Please mention date in DD/MM/YYYY format	Cardiac ailment ______ Date of surgery/ Procedure ______ Name of Surgeon/cardiologist ______ Name of hospital with complete address ______	Cardiac ailment ______ Date of surgery/ Procedure ______ Name of Surgeon/cardiologist ______ Name of hospital with complete address ______	Cardiac ailment ______ Date of surgery/ Procedure ______ Name of Surgeon/cardiologist ______ Name of hospital with complete address ______	Cardiac ailment ______ Date of surgery/ Procedure ______ Name of Surgeon/cardiologist ______ Name of hospital with complete address ______	Cardiac ailment ______ Date of surgery/ Procedure ______ Name of Surgeon/cardiologist ______ Name of hospital with complete address ______	Cardiac ailment ______ Date of surgery/ Procedure ______ Name of Surgeon/cardiologist ______ Name of hospital with complete address ______
4. Have you experienced any below mentioned symptoms post undergoing above mentioned surgery/procedure I. Chest heaviness or Pain II. Difficulty in breathing III. Palpitations IV. Loss of consciousness V. Weakness or dizziness	Enter Option ______	Enter Option ______	Enter Option ______	Enter Option ______	Enter Option ______	Enter Option ______
5. Have you been advised for any other/repeat procedure or admission? If yes please share details	Y N Since______	Y N Since______	Y N Since______	Y N Since______	Y N Since______	Y N Since______
6. Please share following documents, wherever applicable: Discharge summary/Investigation reports /Follow up records/Angiography report/CD/Latest ECHO, ECG, Stress test	Record name ______	Record name ______	Record name ______	Record name ______	Record name ______	Record name ______
7. Hypertension / High Blood Pressure/ High Cholesterol	Y N Since______	Y N Since______	Y N Since______	Y N Since______	Y N Since______	Y N Since______
8. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	Y N Since______	Y N Since______	Y N Since______	Y N Since______	Y N Since______	Y N Since______
9. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please provide the frequency & amount consumed. • Hard Liquor (No. of Pegs in 30 ml per week) and Since • Beer (Bottles/ml per week) and Since • Wine (Glasses/ml per week) and Since • Smoking (no. of Sticks per day) and Since • Gutka/Pan Masala/Chewing Tobacco (Sachets/Grams per day) and Since	Y N	Y N	Y N	Y N	Y N	Y N

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
10. Apart from the cardiac ailment, have you ever been Diagnosed/Suffered/Treated/Taken Medication for any of the following conditions: If Yes, please provide details in additional information section below:						
a) Cancer, tumor, polyp or cyst	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
b) Asthma / Tuberculosis / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
c) Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pituitary tumor/ disease or any other disorder of Endocrine system	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
d) Motor Neuron Disease/ Muscular dystrophies/ Myasthenia Gravis or any other disease of Neuromuscular system (muscles and/or nervous system)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
e) Stroke/ Paralysis/ Transient Ischemic Attack/ Multiple Sclerosis/ Epilepsy/ Mental-Psychiatric-illness/ Parkinsonism/ Alzheimer's/ Depression / Dementia or any other disease of Brain and Nervous System	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
f) Cirrhosis / Hepatitis / Wilson's disease / Pancreatitis / Liver disease / Crohn's disease / Ulcerative Colitis /Piles or any other disease of Mouth, Esophagus, Liver, Gall bladder, Stomach or Intestines or any other part of Digestive System	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
g) Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
h) HIV/SLE/ Arthiritis/ Scleroderma / Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
i) Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
j) Has any of the Proposed to be Insured been hospitalized/ recommended to take investigation/medication or has been under any prolonged treatment/undergone surgery for any illness/injury other than for childbirth/minor injuries	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
k) Are you or anyone of your family member(1st blood relationship) suffering from any of the following conditions: Down's Syndrome/Turner's Syndrome/Sickle Cell Anaemia/ Thalassemia Major/G6PD deficiency	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
l) Any other disease / health adversity / injury/ condition / treatment not mentioned above	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____

Note: The Company shall reject Your proposal and refund the premium amount (after deducting cost of medical tests, if any) in case of incompleteness or any discrepancy highlighted or any other reason.

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Place : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Signature of the Proposer :_____

(On behalf of all the persons to be insured under the Policy)

ADDITIONAL INFORMATION (IF YOUR ANSWER IS 'YES' TO ANY OF THE ABOVE QUESTIONS OR THE PROPOSED TO BE INSURED ARE SUFFERING FROM ANY OTHER PRE EXISITNG DISEASE WHICH IS NOT MENTIONED IN THE ABOVE LIST)

DETAILS OF PREVIOUS OR EXISTING HEALTH INSURANCE

Please fill the following details with respect to health insurance proposals/policies with the Company or any other insurance companies

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Have any of the person(s) to be insured ever filed a claim with their current/previous insurer? If Yes, please provide details on a separate sheet	Y N	Y N	Y N	Y N	Y N	Y N
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	Y N	Y N	Y N	Y N	Y N	Y N
Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company or any other Company without break?	Y N Since_____ (DD/MM/YYYY)	Y N Since_____ (DD/MM/YYYY)	Y N Since_____ (DD/MM/YYYY)	Y N Since_____ (DD/MM/YYYY)	Y N Since_____ (DD/MM/YYYY)	Y N Since_____ (DD/MM/YYYY)

ATTENDING PHYSICIAN'S DETAILS

Name of Family Physician :			
	(First Name)	(Middle Name)	(Last Name)
Contact Number :		Email :	

DECLARATION

a. 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.

b. 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.

c. 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.

d. 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.

e. 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.

Date : / / (DD/MM/YYYY)

Place :

Signature of the Proposer :_____

(On behalf of all the persons to be insured under the Policy)

NEFT DETAILS (FOR CLAIMS & REFUND PURPOSES)

Account Number :		IFSC Code :	
Bank Name :		Bank Branch Name :	
Name of the Account Holder :			

Note : Please submit copy of cancelled cheque along with Proposal Form

I declare that the information given above is true and correct. I hereby authorize Care Health Insurance Limited to directly credit payout/refund, if any, to the above mentioned account and I shall not hold Care Health Insurance Limited responsible for non-credit/non-payment of payout or refund, if any, due to any reason including but not limited to incorrect/incomplete information. Care Health Insurance Limited reserves right to use any alternative payout option such as cheque/demand draft in spite of providing above information.

Date : / / (DD/MM/YYYY)

Place :

Signature of the Proposer :_____

(On behalf of all the persons to be insured under the Policy)

ACKNOWLEDGEMENT FOR PROPOSAL

Please retain this counterfoil for your records

(On behalf of Care Health Insurance Limited)

We acknowledge the receipt of payment of ₹_____ vide Cash/Cheque/DD No./Authorization ID_____ from Mr./Ms._____.

Please note that this is only an acknowledgement receipt and does not amount to acceptance of risk or commencement of the Policy. The Company is not liable for any claim between the time that the proposal amount is received and Policy Start Date. The validity of this receipt is subject to realization of the proposal amount. Acceptance of proposal and issuance of the Policy shall be subject to receipt of the completed Proposal Form, premium payment, medical reports (wherever applicable) and underwriting decision of the Company.

Proposal No.:_____

Signature of the Representative :_____

Name of the Representative :_____

Insurance is a subject matter of solicitation. IRDAI Registration No. 148

Note: Should you choose to pay premium by cash, you are advised to do so only at the nearest Care Health insurance limited branch or any authorized Bank branch, and we insist you to please ask for computerize receipt against the deposited cash against your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.

PREMIUM PAYMENT INFORMATION

Payment By Cash / Cheque / Demand Draft / Card (Strike out whichever is not applicable) :			
Cheque / Demand Draft No. / Authorization ID :			
Payment Amount (₹) :		Premium Amount (₹) :	
Date :		Bank Name :	

In case of payment through Cheque/Demand Draft, the instrument should be drawn in favour of **"Care Health Insurance Ltd."**

Key Exclusions :

(I) Any disease contracted during the first 30 days of the policy start date, except those arising out of accidents.
(ii) 2 Year Wait Period : Non-infective arthritis/Joint replacement/Cataract/Piles/Fissure/Ear, nose and throat (ENT) disorders and surgeries/Stones, etc.
(iii) Pre-existing Diseases : 24 months from the date of the first policy
(iv) Permanent Exclusions : Non-allopathic treatment / Expenses attributable to self-inflicted injury (resulting from suicide, attempted suicide) or alcohol or drug use, misuse or abuse / Cost of spectacles, contact lenses / dental treatment / Medical expenses incurred for treatment of AIDS / Treatment arising from or traceable to pregnancy and childbirth, miscarriage, abortion and its consequences or relating to infertility and in vitro fertilization / Congenital disease.
(v) Treatment/consultation in a hospital which is named in the negative list of hospitals.

For a detailed set of exclusions, please log on to www.careinsurance.com.

Note: Should you choose to pay premium by cash, you are advised to do so only at the nearest Care Health insurance limited branch or any authorized Bank branch, and we insist you to please ask for computerize receipt against the deposited cash against your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.

STATUTORY WARNING

Prohibition of Rebates

(Under Section 41 of Insurance Act 1938)

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 the 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 prospectuses or tables of the Insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

DECLARATION FOR AGENTS

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 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 as per Policy Terms and Conditions and furthermore, 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. (Advisor/Corporate Agent/Broker/Relationship Officer):

Date : / / (DD/MM/YYYY) Signature : _____

SP Name : _____ SP Code :

ADDENDUM – VERNACULAR DECLARATION

I _____, son/daughter of _____, resident of _____ declare that I have read out and fully explained the contents of the Proposal Form and all other accompanying documents in _____ language to the Proposer which is a language understood by him/her and is imperative for the Proposer to avail the insurance from the Company . The contents and import of the proposal have been fully understood by him/her and the replies have been recorded according to the information provided by the Proposer. The replies have also been read out to, fully understood and confirmed by the Proposer.

Date : / / (DD/MM/YYYY) Place :

Name of the Declarant : _____

Signature of the Declarant : _____

(On behalf of all the Proposed to be Insured under the Policy)