

Proposal No.: _____

- /er: July/23/AS

☐ CAMSRep- CAMSRepository Services Limited	☐ NDML – NSDL Data Management Limited
☐ Karvy Insurance Repository Limited	☐ CIRL-Central Insurance Repository Limited (CDSL)

NOMINEE DETAILS

Details	Nominee 1	Nominee 2	Nominee 3
Name			
Date of birth	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)
Age			
Relationship with Proposer			
Specify the percentage (%) of the claim amount payable to each nominee in the event of the policyholder's death. The total percentage of contribution across all the nominee must not exceed 100%			
Correspondence Address (If same as Proposer please tick here) ☐			
Permanent Address (If same as Proposer please tick here) ☐			
Mobile No.			
E-mail ID			
Bank Account No			
IFSC/ MICR Code			
Bank Name			
Name of the Account Holder			

Appointee Name	Age	Mobile No.	Email ID	Relationship with Minor

POLICY DETAILS

[illegible][illegible]

II. Difficulty in breathing						
III. Palpitations						
IV. Loss of consciousness						
V. Weakness or dizziness						
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.	☐ Y ☐ N ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____	☐ Y ☐ N ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____	☐ Y ☐ N ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____	☐ Y ☐ N ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____	☐ Y ☐ N ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____	☐ Y ☐ N ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____
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:	☐ Y ☐ N Since_____	☐ Y ☐ N Since_____	☐ Y ☐ N Since_____	☐ Y ☐ N Since_____	☐ Y ☐ N Since_____	☐ Y ☐ N Since_____
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/ Arthritis/ 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.

[illegible]

(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 EXISTING DISEASE WHICH IS NOT MENTIONED IN THE ABOVE LIST)

ATTENDING PHYSICIAN'S DETAILS

[illegible]

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 Care Health Insurance?	☐ Y ☐ N Since_____	☐ Y ☐ N Since_____	☐ Y ☐ N Since_____	☐ Y ☐ N Since_____	☐ Y ☐ N Since_____	☐ Y ☐ N Since_____
	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)

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 including seeking and/or sharing of my medical data through ABHA.

Date :

 /

 /

 (DD/MM/YYYY)

[illegible]

Signature of the Proposer /Authorized Representative* : _____

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

*Only Applicable where proposer is a person with a disability and who has appointed an authorized representative

NEFT DETAILS (FOR CLAIMS & REFUND PURPOSES)

[illegible]

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)

[illegible]

Signature of the Proposer / Authorized Representative* : _____

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

*Only Applicable where proposer is a person with a disability and who has appointed an authorized representative

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."

For Premium computation, Zone shall be considered as per Correspondence address

Key Exclusions :

- Any disease contracted during the first 30 days of the policy start date, except those arising out of accidents.
- 2 Year Wait Period : Non-infective arthritis/joint replacement/Cataract/Piles/Fissure/Ear; nose and throat (ENT) disorders and surgeries/Stones, etc.
- Pre-existing Diseases : 24 months from the date of the first policy
- 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.
- 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)

- 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.
- 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

Applicable where the Proposer is not able to read/write/ has signed in vernacular language or is suffering from a disability due to which writing is restricted.

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)

ACKNOWLEDGEMENT FOR PROPOSAL

Please retain this counterfoil for your records

(On behalf of Care Health Insurance Limited)

Proposal No : _____

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.

Signature of the Representative : _____

Name of the Representative : _____

Insurance is a subject matter of solicitation. IRDAI Registration No. I 48

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.

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: CHIHLP26053V032526 IRDAI Registration No. - 148