care HEALTH

carē plus

Proposal Form

URN: CHIL / R / HE / 092 / 22-23

Proposal No.:___

- To be filled in by the Proposer in CAPITAL LETTERS only.
- 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. 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. The proposed policyholder will be referred to in this Proposal Form as "Proposer", "You" or "Your". 2. З
- 4.

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 f	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:
Aadhar Card No.:	PAN Card No.:
PROPOSER DETAILS	
Name : (Mr./Ms./Mrs.)	
Company on dance Address ((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 t	for WhatsApp notifications related to your Care Health Insurance Policy 😥
Date of Birth / Incorporation (in case Proposer is	s an entity) : D V 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
CKYC :	(By signing the Proposal form 1 give my consent for using my Aadhaar No. for Authentication of my Aadhaar Details)
Please share the following for authentication purpo	ise:
Prostofidentity (POI)	
Proof of Identity (POI) (Tick whichev	
PAN Aadhaar Passport	Driving License Voter ID Card
Letter from a recognized public authority or publics	ervant 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 s	ervant 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: CHIHLIP22047V012122 IRDAI Registration No. - 148

April/24/AP

Would you like to opt for Electronic Policy Issu If you have an eIA, please provide following de	0	count (eIA) o	f an Insurance Repos	itory? Ye	S	No	
I) Name of Insurance Repository:							
ii) elANo:							
iii) Name as appearing in elA :							
If you do not have an eIA, would you like to ope If Yes, choose any one Insurance Repository:	en an account?	Yes	No				
NDML–NSDL Data Management Lim	ited		CAMSRep-	CAMS Insurance Repo	ository & Services		
Karvy Insurance Repository Limited			CIRL-Cent	ral Insurance Repositor	y Limited (CDSL)		
Help us preserve the environment by opting to	o receive policy related informat	tion in soft cop	py/via email only :	Yes	No		
POLICY DETAILS							
Sum Insured (in Rs.):			Tenure:	l Year 🗌	2 Year 🗌	3 Year 🗌	
Cover Type: Ind	lividual 🗌 🛛 Floater 🗌						
Optional Benefit Opted : Details of Optional Benefit(s) as per Annexure - I	Yes 🗌 No 🗌						
Are you applying for portability?	Yes 🗌 No 🗌	(If yes, p	lease fill in the separa	te Portability Form)			
NOMINEE DETAILS							
Details	Nominee I		No	minee 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%							

Appointee Details (Only whe	ere the Nominee	age is less than 18 years)		
Appointee Name	Age	Mobile No.	Email ID	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 form. The receipt of the proceeds by the Nominee/ Beneficiary would be sufficient discharge to the Company. The Nominee for all the other person(s) proposed to be insured shall be the Proposer himself.

In case you want to provide more than 3 nominees, please either provide a separate application or add the nominee via our website through Endorsement.

DETAILS OF THE PROPOSED TO BE INSURED INCLUDING PROPOSER

Insured I : Nan	ne : Mr./N	1s./Mrs.																									
Height	cms	Marital Status					Da	ate of Birth	D	D	M	M	Y	Y	Y	Y	An	nual	Inco	me	(In Lacs	s):	₹				
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City of Residence :										0	Dccu	patio	on :														
Do you have ABHA No. Yes No If Yes, please provide ABHA Number (O																											
Insured 2 : Name : Mr./Ms./Mrs.																											
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Weight Kg Gender Male Female Others									Aad	dhaa	r/PA	ΝN	Vo. ((Opt	tiona	al)											
Nominee (Relationship with Insured): Relationship with Proposer :																						lf F	EP*	:	Yes	No	
City of Residence :										0	Dccu	patio	on :														
Do you have ABHA No. Yes No I If Yes, please provide ABHA Number (Opti								ptior	nal)																		

Correspondence Address (If same as Proposer please tick here) $\hfill \square$ Permanent Address (If same as Proposer please tick here)

Name of the Account Holder

Mobile No. E-mail ID Bank Account No IFSC/ MICR Code Bank Name

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: CHIHLIP22047V012122 IRDAI Registration No. - 148

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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: CHIHLIP22047V012122 IRDAI Registration No. - 148

10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or	Y N	Y N	Y N	Y N	Y N	Y N
reproductive organs?	Since	Since	Since	Since	Since	Since
 HIV/SLE/ Rheumatoid Arthiritis/ Scleroderma / Sarcoidosis/ Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone 	Y N	YN	Y N	Y N	Y N	Y N
marrow/ Immunity or Skin.	Since	Since	Since	Since	Since	Since
12. Disease or disorder of eye, ear, nose or throat (except any sight related	Y N	YN	Y N	YN	Y N	Y N
problems corrected by prescription lenses)?	Since	Since	Since	Since	Since	Since
13. Disease of the musculoskeletal system /Orthopedic disorders/Degeneration,Fracture or dislocation of bones or joints/	YN	YN	YN	YN	YN	YN
avascular necrosis of joints or any other disorder related to it?	Since	Since	Since	Since	Since	Since
14. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please indicate the following:	Y N	YN	Y N	YN	Y N	Y N
recreational drugs. If ites then please indicate the following.	Since	Since	Since	Since	Since	Since
- Hard Liquor (No. of Pegs in 30 ml per week)						
- Beer(Bottles/ml per week)						
- Wine(Glasses/ml per week)						
- Smoking (no. of Sticks per day)						
- Gutka/Pan Masala/Chewing Tobacco(Sachets/Grams per day)						
15. Any other disease / health adversity / injury/ condition / treatment not	Y N	YN	Y N	YN	Y N	Y N
mentioned above?	Since	Since	Since	Since	Since	Since
16. Has any of the Proposed to be Insured been	YN	YN	Y N			Y N
hospitalized/recommended to take investigations/medication or has been under any prolonged treatment/ undergone surgery for any	Since	Since	Since	Since	Since	Since
illness/injury other than for childbirth/minor injuries?	Since	Since	Since	Since	Since	3IIICe
17. Has any of the Proposed to be Insured have been suffering/suffered	YN	YN	YN	Y N	YN	
from Covid-19 disease?	Since	Since	Since	Since	Since	Since
If you confirm if any complication onice due to could 10	50000	JIIICC	51100	JIIICC	Jinec	JIICC
If yes, confirm if any complications arise due to covid-19						
Note: The Company shall reject Your proposal and refund the premium amo	unt (after deductin	or cost of medical t	ests if any) in case	of incompleteness	or any discrepancy	/ highlighted or any

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.

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.

Particulars	Insured I	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	YN	YN	Y N
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	XN	Y N	Y N	YN	Y N	Y N
Is any of the person(s) proposed for insurance covered under any other	YN	Y N	YN	YN	Y N	Y N
health insurance policy with the Company or any other Company without break?	Since	Since	Since	Since	Since	Since
Uleak:	(DD/MM/YYYY)				(DD/MM/YYYY)	

ATTENDING PHYSICIAN'S D	DETA	LS														
Name of Family Physician :																1
(First Name)								 ddle Na	me)			(Last Nar	ne)		
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 including seeking and/or sharing of my medical data through ABHA.

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Date	:		1/		/			(DD/	'MM/'	YYY	Y)			Signat	ureoft	he Pr	ropose	r/Au	thoriz	zed Re	presenta	ative*		
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Place														(On be	ehalf of a	llthe	persons	stobe	insure	ed unde	er the Polic	CV)		

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

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: CHIHLIP22047V012122 IRDAI Registration No. - 148

NEFT DETAILS (FOR CLAIMS & REFUND PURPOSES)		
Account Number :		
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 Inserponsible 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 draft in spite of providing above information.		
Date : / / / / (DD/MM/YYY) Signature of the Proposer/Authorized Representative* :		
*Only Applicable where propose is a person with a disability and who has appointed an authorized representative PREMIUM PAYMENT INFORMATION		
Payment By: Cash / Cheque / Demand Draft / Card /ECS (NACH)/Reward Points/Wallet/Any other mode (Strike out whichever is not applicable)		
Premium payment mode: Single Monthly Quarterly Half-yearly (D Tick whichever is applicable)		7
Cheque / Demand Draft No. / Authorization ID :		_
Payment Amount (₹): Premium Amount (₹):		_
Date : Bank Name :		
If ECS is selected, please submit the standing instruction form available at our branches. In case of payment through Cheque/Demand Draft, the instrument should be drawn in favour of " Care Health Insurance Ltd. "		
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	leposited cash	against
your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.		
STATUTORY WARNING		
Prohibition of Rebates	r	
(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 th		ut 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 publ		
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	that I have ov	relained
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 quest 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 explaine statement(s)/information/response(s) is/are contained in this Proposal Form (s), affidavits, statements, submissions, furmished/to be furnished, the Company shall have the right to vary the benefits which may b 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 un	ions contained d that if any e payable as per	d herein untrue r Policy
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		
Date : / / / / Signature of the declarant :		
Place : (On behalf of all the Proposed to be Insured under the Policy)		
Name of the declarant :		
ANNEXURE – I: OPTIONAL BENEFITS		
Optional Benefit: Maternity & New Born Cover: Y		
Optional Benefit: Daily Allowance		
Optional Benefit: International Second Opinion :		
Optional Benefit: Smart Select		
Optional Benefit: Deductible Options : Y N If Yes, then please mention Deductible (in INR):		
Optional Benefit: Co-Payment Option : Y N		
Optional Benefit: Room Rent Modification : Y		
Acknowledgement for Proposal	11	
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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: CHIHLIP22047V012122 IRDAI Registration No. - 148