Proposal Form

URN : CHIL / R / HE / 107 / 23-24

Proposal No.:_____

GUIDELINES FOR COMPLETION OF THE FORM

1 This policy is specially designed for Persons with Disability, Mental Illness and Persons with HIV/AIDS.
   a. Persons with Disability shall be covered if 40% or more disability is certified by the Medical Board appointed by the government for certifying Disability as per the Disability Act 2016.
2 Please answer all questions correctly and completely.
3 Only Indian Nationals can be covered under this policy.
4 Note: The Coverage proposed for insurance is not covered until the proposal is accepted and premium is paid and the same is realized by Care Health Insurance Limited.

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 :			
Profession :	Salaried ☐ Self-Employed ☐ Other ☐	Details:	
Occupation and Nature of Business/Work:			
PAN No./ form 60/61:		AADHAAR No.:	X X X X X X X X

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

CKYC :	

Phone* : _____ E-mail : _____

Date of Birth D D M M Y Y Y Y Gender: Male ☐ Female ☐ Other ☐

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

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 ☐

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

COVERAGE DETAILS

Policy Type:	Individual Basis
Policy period:	1 year
Period of Insurance:	From D D M M Y Y Y Y to D D M M Y Y Y Y
Sum Insured:	₹400,000 ☐ ₹500,000 ☐
Coverage opted:	Pre-existing HIV/AIDS ☐ Pre-existing Disability ☐ Pre-existing HIV/AIDS and Disability ☐

OPTIONAL COVER

Waiver of co-payment	Yes ☐ No ☐
Deductible Option	Yes ☐ No ☐ If Yes please select - ₹25,000 ☐ ₹50,000 ☐ ₹100,000 ☐ ₹200,000 ☐

DETAILS OF PERSONS TO BE INSURED

Sr. No	Name of the Insured	Nationality	Date of Birth	Age	Gender	Height	Weight	Occupation	Marital Status	Relation with Proposer	PEP*
1.											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, for example, 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.

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 Details (Only where 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.

PREVIOUS/EXISTING HEALTH DETAILS OF INSURED

Do you suffer from HIV/AIDS?	Yes ☐ No ☐	If Yes, please enclose a recent certificate of your current CD4 count (within past 30 days)			
Current CD 4 count					
Has your CD4 Count gone below 500 in the past 4 years?	Yes ☐ No ☐	If yes when and How many times:			
Do you suffer from any other illness/ disease related to/ arising of/ associated to HIV/AIDS?	Yes ☐ No ☐	If Yes please give details:			
Do you suffer from any disability as per the listed conditions mentioned below:	Yes ☐ No ☐	If Yes, please enclose Disability certificate mentioning percentage of disability wherever applicable.			
1.Blindness ☐	2.Muscular Dystrophy ☐	3.Low vision ☐	4.Chronic Neurological conditions ☐	5.Leprosy Cured persons ☐	
6.Specific Learning Disabilities ☐	7.Hearing Impairment (deaf and hard of hearing) ☐	8.Multiple Sclerosis ☐			
9.Locomotor Disability ☐	10. Speech and Language disability	11. Dwarfism ☐	12. Thalassemia ☐	13. Intellectual Disability ☐	
14. Haemophilia ☐	15. Mental Illness ☐	16. Sickle Cell disease ☐	17. Autism spectrum disorder ☐		
18. Multiple Disabilities including deaf/ blindness ☐	19. Cerebral Palsy ☐	20. Acid Attack victim ☐	21. Parkinson's disease ☐		
Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above?	Yes ☐ No ☐				
If Yes, please specify below:					

Has 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. Cancer, tumor, polyp or cyst	Yes ☐ No ☐ Since_____
2. Any heart disease or disorder, chest pain or discomfort, irregular heartbeats, palpitations or heart murmur	Yes ☐ No ☐ Since_____
3. Hypertension / High Blood Pressure(BP)/ High Cholesterol/Any other Lipid disorders	Yes ☐ No ☐ Since_____
4. Asthma / Tuberculosis (TB) / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease ?	Yes ☐ No ☐ Since_____
5. Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pituitary tumor/ disease or any other disorder of Endocrine system ?	Yes ☐ No ☐ Since_____
6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	Yes ☐ No ☐ Since_____
7. Motor Neuron Disease/ Muscular dystrophies/ Myasthenia Gravis/ Demyelinating disease or any other disease of Neuromuscular system (muscles and/or nervous system)	Yes ☐ No ☐ Since_____
8. 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?	Yes ☐ No ☐ Since_____
9. Cirrhosis / Hepatitis / Wilson's disease / Pancreatitis / Liver disease / Crohn's disease / Ulcerative Colitis / Inflammatory Bowel Diseases/ Piles or any other disease of Mouth, Esophagus, Liver, Gall bladder, Stomach or Intestines or any other part of Digestive System?	Yes ☐ No ☐ Since_____
10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs?	Yes ☐ No ☐ Since_____
11. HIV/SLE/ Rheumatoid Arthiritis / Scleroderma / Sarcoidosis/ Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin.	Yes ☐ No ☐ Since_____
12. Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses)?	Yes ☐ No ☐ Since_____
13. Disease of the musculoskeletal system /Orthopedic disorders/Degeneration, Fracture or dislocation of bones or joints/ avascular necrosis of joints or any other disorder related to it?	Yes ☐ No ☐ Since_____
14 Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please indicate the following:	Yes ☐ No ☐ 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 mentioned above?	Yes ☐ No ☐ Since_____
16. Has any of the Proposed to be Insured been hospitalized/recommended to take investigations/medication or has been under any prolonged treatment/ undergone surgery for any illness/injury other than for childbirth/minor injuries?	Yes ☐ No ☐ Since_____
17. Has any of the Proposed to be Insured have been suffering/suffered from Covid-19 disease? If yes, confirm if any complications arise due to covid-19	Yes ☐ No ☐ Since_____

Do you have any other physical disability arising out of any illness I disease condition? _____
Any other previous medical details _____

PREVIOUS/EXISTING HEALTH INSURANCE DETAILS

Policy No. / Application No.	Insurer Name	Period of Insurance (from – to)	Sum Insured	Claims lodged during the preceding years

Do you have the same policy from any one or other insurer? Yes ☐ No ☐

Policy No. / Application No.	Insurer Name	Period of Insurance (from – to)	Sum Insured	Claims lodged during the preceding years

Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)? Yes ☐ No ☐

ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

I want_____ related information in – Physical Format: Yes ☐ No ☐
e-Format (electronic) as & when applicable: Yes ☐ No ☐

Choose your Insurance Repository (For those selecting e-Format)
(a)NSDL Data Management Ltd. ☐ (b)CDSL Insurance Repository Ltd ☐
(c)Karvy Insurance Repository Ltd. ☐ (d)CAMS Repository Services Ltd ☐

I have e Insurance Account & the No. is

My CKYC No. (Central Know Your Customer registry number) is (If available)

PREMIUM PAYMENT DETAILS

Name of Premium payer:			
Premium Payment Frequency:	Monthly / Quarterly / Half Yearly/ Single		
Premium Amount: (in ₹):			
Instrument Type:	Cash/ Cheque/ Debit Card/ Credit Card/ Others:		Please Specify:
Date: D D M M Y Y Y Y	Cheque no.:		
Bank Name:		Bank Account Number:	
IFSC Code:	Branch Name:		

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 deposited cash against your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.

BANK ACCOUNT DETAILS FOR PROCESS OF REFUND

Cheque will be issued in the name of the Proposer only.

In case of cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit Card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund/ claim into your bank account:(Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly.

Name of Account holder:	
Cheque No:	
Bank Name:	
Branch Name:	
Cheque Date:	
Cheque Amount for ₹	
Name as in Bank Account:	
Bank Account No:	
IFSC Code:	
MICR Code:	

Note: The Proposer agrees and undertakes to intimate in writing to Care Health Insurance Limited about any change in bank account details.

If ECS is selected, please submit the standing instruction form available at our branches.

Place : Signature of proposer/ Authorized Representative*:_____

Date : / / (DD/MM/YYYY)

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

AML GUIDELINES

I/ We hereby confirm that all premiums have been/ will be paid from bonafide sources and no premiums have been/ will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002. I/We understand that the Company has the right to call for documents to establish source of funds. The insurance Company has the right to cancel the insurance contract in case I am/ have been found guilty by any competent court of law under any statues, directly or indirectly governing the prevention of money laundering in India.

Date : / / (DD/MM/YYYY)

Place : Signature : _____

AGENT'S DECLARATION

I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised 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 the 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 and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour 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.

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

Place : Licence No. : _____

DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

I. I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements 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.

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

iii. 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.

iv. I/We declare and further consent to the company. Seeking medical information from any 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 and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application or insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and /or claim settlement.

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

vi. I/We aware of premium loading, (if any declared above) for habit's & diseases as declared / mention by me/ us above.

vii. I/ We hereby agree to keep record of KYC details of all the individual members covered under the group insurance, and ensure to provide the details of beneficiaries to the Company as and when required.

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

Place : | | | | | | | | | | | | | | | 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

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/We certify that the product applied for by me/us and the contents of the Proposal Form have been clearly explained to me/us and I/we have fully understood them. I/We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/us. I, (Full name of the witness) _____ (Relation with the Proposer)_____ adult and inhabitant of (city)_____ and residing at _____ do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the insurance policy from Care Health Insurance Limited., to the Proposer and he/she/they have understood the same. I/we declare that whatever I/we have stated herein above is true and correct to the best of knowledge and belief.

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

Signature of the Witness :_____ Signature/Thumb impression of the Proposer:_____

SECTION 41 OF INSURANCE ACT, 1938

As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited, as follows:

(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 or risk relating to lives or property in India, any rebate of 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 punishable with fine , which may extend to Rupees Ten Lakhs.

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. 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.