

carē supreme™

Proposal Form

URN: CHIL / R / HE / 124 / 24-25

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".

PROPOSER DETAILS																									
Name : (Mr/Ms./Mrs.)								Т																	
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Date of Birth / Incorporation (in case Proposer is				DIM		ΙΫ́		/	7		Gender :					F	ema	ale			(Othe	rs [
Marital Status : Single		rried					Divor	red			Wic	low(e	r)			Sep	arat	ted							
Mother's Name :							3.75.				1	1	,												
PAN Number:		+		+					Vationa	lity ·	Indiar		Ot	her t	han	l India	n								
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CKYC:																									
Please share the following for authentication purpose : Proof of Identity (POI) (Image: Tick whichever is applicable)																									
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Letter from a recognized public authority or publi		nt ve	rifving		_			nce	of the	Propo			L												
Proof of Address (POA) (Tick whichever is ap			/8			Cal I	0.00.00			М															
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Letter from a recognized public authority or publi	ic sei va	III VE	i ii yii ig	lile ic	ientit)	y alli	u reside	ence	or the	ггорс)sei														
Would you like to opt for Electronic Policy Issuance to If you have an el A, please provide following details:	hrough	ı an e	-Insurai	nce A	ccour	nt (el	IA) of ar	n Ins	urance	Repos	sitory?	Yes			1	Vo [
I) Name of Insurance Repository:																									
II) elANo:																									
III) Name as appearing in eIA:																									
If you do not have an elA, would you like to open an a If Yes, choose any one Insurance Repository:	account	?				Ye	es			Ν	0														
☐ CAMSRep – CAMS Insurance Repository & Services									ND	ML-1	NSDLD	ata M	anag	eme	nt L	imite	d								
☐ KARVY Insurance Repository Limited									CIR	L-Ce	ntral Insu	urance	e Re _l	oosit	ory	Limit	ed								
Help us preserve the environment by opting to rece	ive poli	cyrel	ated inf	forma	tion ir	nsof	t copy/	via e	mail on	ly: Ye	es			No	o [

Details	Nominee I	Nominee 2	Nominee 3										
Name													
Date of birth Age	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)										
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 Notation Appointee Name Age	Mobile No.	Email ID	Polationship with Minor										
Appointee Name Age	Proble No.	EMAILD	Relationship with Minor										
			The receipt of the proceeds by the Nominee/										
Beneficiary would be sufficient discharge to	the Company. The Nominee/ Beneficiary fo	r all the other person(s) proposed to be insur	ed shall be the Proposer himself.										
In case you want to provide more than 3 no	minees, please either provide a separate app	lication or add the nominee via our website th	rough Endorsement.										
POLICY DETAILS			•										
Sum Insured (in Rs.):		Tenure: Year	2 Year 3 Year										
/ 1	ndividual Floater Floater												
Details of Optional Cover(s) as per Annexure - I Are you applying for portability? Yes \[\] No \[\] (If yes, please fill in the separate Portability Form)													
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Insured I: Name: Mr./Ms./Mrs.													
Height CMS Marital Status	Date of Bir	rth DDMMYYYYAnnu	al Income (In Lacs): ₹										
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Insured 6 : Na	me : Mr./1	Ms./Mrs.								
Height		Marital Sta	atus		Date of Birth	D M M Y Y Y A	nnual Income (In Lac	es) : ₹		
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 AB	HA No.	Yes 🗌	No 🗌	If Yes, please provide	ABHA Number (Opt	ional)				
*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 total										

Particulars 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:	Insured I	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Suffered/Treated/Taken Medication for any of the following conditions: If						ilisureu o
Cancer, tumor, polyp or cyst	Since	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since
Any heart disease or disorder, chest pain or discomfort, irregular heartbeats, palpitations or heart murmur	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since
Hypertension / High Blood Pressure(BP)/ High Cholesterol/Any other Lipid disorders	Y N Since	Y N	Y N Since	Y N Since	Since	Y N Since
4. Asthma / Tuberculosis (TB) / 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	Since
5. 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	Y N Since	Y N Since
Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	Y N Since	Since	Since	Y N Since	Y N Since	Y N Since
7. Motor Neuron Disease/ Muscular dystrophies/ Myasthenia Gravis/ Demyelinating disease or any other disease of Neuromuscular system (muscles and/or nervous system)	Y N Since_	Y N Since	Y N Since	Since	Y N Since	Y N 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?	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since	Y N 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?	Y N Since_	Since	Since	Y N Since	Y N Since	Y N Since
10. 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
 HIV/SLE/ Rheumatoid Arthiritis / Scleroderma / Sarcoidosis/ 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
12. Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses)?	Since_	Y N Since	Since	Y N Since	Y N Since	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?	Since	Y N Since_	Since	Y N Since	Y N Since	Y N Since
14. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please indicate the following:						
- 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?	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since	Y N 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?	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since
17. Has any of the Proposed to be Insured have been suffering/suffered from Covid-19 disease?	Y N Since	Y N	Y N Since	Y N Since	Y N Since	Y N Since
If yes, confirm if any complications arise due to covid-19.						

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

Please if the following details with respect to health misrared proposal follows with the Company of any other insurance companies Lisea says of the presenting is suircured and respect to health misrared proposal follows with the company of any other insurance or proposal follows and insurance of a misrared in the proposal proposal for insurance or proposal for insurance covered under any other contents of supplies or proposal for insurance covered under any other contents of supplies or proposal for insurance covered under any other contents of supplies or proposal for insurance covered under any other contents of supplies or proposal for insurance covered under any other contents of supplies or proposal for insurance covered under any other contents of supplies or proposal for insurance covered under any other contents of supplies of the contents of insurance covered under any other contents of supplies of the contents of insurance covered under any other	ADDITIONAL INFORMATION (IF YOUR ANSWER INSURED ARE SUFFERING FROM ANY OTHER PRE											
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Comment for previous in numerical files, places provide details in an assparate short of the say of your provides (for Hosth Instrume been added), and previously for Hosth Instrume been added, duringed a higher premium or issues with special condition(s).			. , ,			Insured 5	Insured 6					
Like any of your proposely for liceth insurance connected condition(s)? Any of the person(s) proposed for insurance covered under any other seath time states path) with the Company of any other Company without for the person(s) proposed for insurance covered under any other seath time states path) with the Company of any other Company without for the person of the person(s) proposed for insurance covered under any other seath time states path) with the Company of any other Company without for the person of the per		YN	YN	YN	YN	YN	YN					
PECLARATION 1. The record decision, which the Company or stay other Company without Since	Has any of your proposal(s) for Health insurance been declined,		YN	YN	YN	YN	YN					
DECLARATION 1. Howely doles as on my hallst and on behalf all persons proposed to be invared, then the above externers is mover and for particulars given by nie are true and complete in all persons of the persons of		YN	YN	YN	YN	YN	YN					
Interdoy declare, on my her all grad on behalf of all persons proposed to be insured. What is above statements array for particulars given by me are true and complete in all behalf of the person o												
respects to the best of my nowledges and with a misunfortise charge propose on behalf of these other persons. Indicating that the information or provided by me will form the bass of the insurance pocking is able to the Beard approved underwriting policy of the insuran and that the policy will corrective formation for constructive for proposed has been submitted but of the proposed has been submitted by the proposed has been submitted	DECLARATION											
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 /ECS (NACH)/Reward Points/Wallet/Any other mode (Strike out whichever is not applicable) Premium payment mode: Single Monthly Quarterly Half-yearly (ZTick whichever is applicable) Cheque / Demand Draft No. / Authorization ID: Premium Amount (₹): Date: Bank Name: Premium Amount (₹): Date: Date: Premium Amount (₹): Date: Premium Amount (₹): Date: Date: Date: Premium Amount (₹): Date: Da	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 : // // Signature of the Proposer/Authorized Representative:											
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 (gT Tick whichever is applicable) Cheque / Demand Draft No. / Authorization ID: Payment Amount (\$): Bank Name: Permium Amount (\$): Bank Name: It (Si Specied place submit the standage instruction forms aliable at our important death against spour frought of the memory of the gas Demand Only the memory and should be done in facur of "Care Health Insurance Limited" Notes Should you shows to pay premium by cash, you are ashiest to do so only at the nearest Care Health Insurance Limited or "Amortization in the plant and amount of first the deposited cash against your frought Any Julian without computerated recepts against the deposited cash against your frought Any Julian without computerated recepts against the deposited cash against your frought Any Julian without computerated recepts against the deposited cash against your frought Any Julian without computerated recepts against the deposited cash against your frought Any Julian without computerated recepts against the deposited cash against your frought Any Julian without computerated recepts against the deposited cash against your frought against your frought against and any Julian without computerated recepts against the deposited cash against your formation of the surface of the whole or part of the Notes of Health Insurance Limited or of the Julian without the Julian wi	Place: *Only Applicable where proposer is a person with a disability and who has appointed an authorized representative											
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For Premium computation, Zone shall be considered as per Correspondence address If ECS is selected, please submit the standing instruction form available at our branches. In case of payment through Chemic Demand Draft, the instrument show also drawn in favour of "Care Health Insurance Limited" Note: Should you choose to pay premium by cash, you are added do so so only at the nearest Care Health Insurance limited branch or any authorized Bank branch, and we insist you to please ask for computerized recept against the deposted cash against your Proposal. Any claim without computerized recept against the deposted cash will not be admitted. *2 months premium to be paid in advance for freshvienewal premium payment through NACH or standing instruction (where payment is made either by direct debit of bank account/debit card/credit card) **STATU ORY WARNING** Prohibition of Rebates (Under Section 1 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 Insurance. **NEFT DETAILS (FOR CLAIMS & REFUND PURPOSES)* Account Number: Bank Name: 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-ore-excition-payment of payout or refund if any, clue to any authorized representative **Only Applicable where proposer is a person with a disability and who has appointed an auth		Premium Am	ount (₹):									
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In case of payment through Chiesque/Demand Draft, the instrument should be drawn in Secure of "Care Health Insurance Limited" 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 computerated receipt against the deposited cash will not be admitted. *2 months premium to be paid in adviance for fresh/renewal premium payment through NACH or standing instruction (where payment is made either by direct debit of bank account/debit card/credit card) **TATUTORY WARNING** Prohibition of Rebates (Under Section 14 of Insurance Act 1938) 1. No person hall 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 Insurance. 2. Any person making default in complying with the provisions of this section shall be fable for a penalty which may extend to ten lisk in rupes. **NEFT DETAILS (FOR CLAIMS & REFUND PURPOSES)** Account Number: IFSC Code:												
your Proposal Any claim without computerized recept against the deposted cash will not be admitted. *2 months premium to be paid in advance for fresh/renewal premium payment through NACH or standing instruction (where payment is made either by direct debit of bank account/debit card/credit card) **TATUTORY WARNING** Prohibition of Rebates (Under Section 41 of Insurance Act 1938) 1. No person shall allow or offerto 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 finance: 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. **NEFT DETAILS (FOR CLAIMS & REFUND PURPOSES)** Account Number: Bank Name:		re Health Insurance I	_imited"									
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. NEFT DETAILS (FOR CLAIMS & REFUND PURPOSES) Account Number: Bank 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 chequel/demand draft in spite of providing above information. Date:	your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.		,				he deposited cash against					
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Signature of the Declarant/Authorized Representative*:*Only Applicable where proposer is a person with a disability and who has appointed an authorized representative	I declare that the information given above is true and correct. I hereby authorize Care Health Insu responsible for non-credit/non-payment of payout or refund, if any, due to any reason including but											
*Only Applicable where proposer is a person with a disability and who has appointed an authorized representative	Date : / / / (DD/MM/YYY)			Place:			_					
	Signature of the Declarant/Authorized Representative*:											
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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: CHIHLIP25047V022425 IRDAI Registration No. - 148

FOR OFFICE USE ONLY																								
Intermediary Details																								
Intermediary Code :						In	term	nediar	y Nam	ne :					\top									
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ADDENDUM – VERNACULAR DE	CL/	ARAT	ION								7													
Applicable where the Proposer is not able to read/write/ has signe	ed in ve	rnacular la		is suffering t	from a disa	bility due t	to whic		-															
I, son/daugt fully explained the contents of the Proposal Form and all other ac	ter of . compa	nying docu	ments in _						, res			langu	uage t	o the Pr	ropos	er wh	ich is a	anguas	ge unde	erstoo				ad out and erative for
the Proposer to avail the insurance from the Company . The corbeen read out to, fully understood and confirmed by the Propose	1			posal have	been fully (understoo	od by h													d by th	ne Prop	oser. Th	e replie	s have also
Date : / / /	1 .)/MM/Y							Place :															
Name of the Declarant :						-		S	ignatu	re of	the [Decla	rant	:										
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ANNEXURE – I: OPTIONAL COVERS	
Optional Cover – I : Smart Select: Yes No	
Optional Benefit -2: Room Rent Modification: Yes No	
Optional Benefit – 3 : PED Wait Period Modification : Yes No	
(If Yes, then please mention modified no. of months)	
Optional Benefit – 4: Named Ailment Wait Period Modification: Yes No	
(If Yes, then please mention modified no. of months)	
Optional Benefit – 5: Instant Cover: Yes No	
Optional Benefit – 6: Deductible: Yes No	
(If yes, then please mention the deductible amount opted):	
Optional Benefit – 7: Co-Payment: Yes No	
(If yes, then please mention the Co-pay %):	
Optional Benefit – 8: New Born cover: Yes No	
Optional Benefit – 9: Plus Benefit: Yes No	
Optional Benefit – 10: Cumulative Bonus Super: Yes No	
Optional Benefit – I I : Annual Health checkup : Yes No	
Optional Benefit – 12: Be-Fit Benefit: Yes No	
Optional Benefit – I 3 : Wellness Benefit: Yes No	
Optional Benefit – I 4: Air Ambulance Cover: Yes No	
Optional Benefit – 15: Women Care benefit: Yes No	
Optional Benefit – I 6: Mental Health wellbeing: Yes No	
Optional Benefit – 17: Claim Shield: Yes No	
Optional Benefit – 18 : Unlimited Care: Yes No	
Optional Benefit – 19: True Connect: Yes No	
ACKNOWLEDGEMENT FOR PROPOSAL	
	(On bobalf of Caro Hoalth Income and insite of)
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	
Mr./MsPlease note that this is only an acknowledgement receipt and does not amount to ac 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 reali	cceptance of risk or commencement of the Policy. The ization 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 under	
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 author computerize receipt against the deposited cash against your Proposal. Any claim without computerized receipt against the deposited cash will not be admitt	