

# Proposal Form

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

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".

## PROPOSER DETAILS

[illegible]

\*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) :  Gender : Male ☐ Female ☐ Others ☐

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

[illegible]

CKYC:

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

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:

[illegible]

If you do not have an eIA, would you like to open an account?

If Yes, choose any one Insurance Repository:

<input type="checkbox"/> CAMSRep – CAMS Insurance Repository & Services	<input type="checkbox"/> NDML – NSDL Data Management Limited
<input type="checkbox"/> KARVY Insurance Repository Limited	<input type="checkbox"/> CIRL – Central Insurance Repository Limited

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

## 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) <input type="checkbox"/>			
Permanent Address (If same as Proposer please tick here) <input type="checkbox"/>			
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/ Beneficiary 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.

## POLICY DETAILS

Sum Insured (in Rs.):		Tenure:	1 Year <input type="checkbox"/>	2 Year <input type="checkbox"/>	3 Year <input type="checkbox"/>
Cover Type:	Individual <input type="checkbox"/>	Floater <input type="checkbox"/>			
<b>Details of Optional Cover(s) as per Annexure - I</b>					
Are you applying for portability?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(If yes, please fill in the separate Portability Form)		

## DETAILS OF THE PROPOSED TO BE INSURED INCLUDING PROPOSER

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

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: CHIHLP25047V022425 IRDAI Registration No. - 148

[illegible]**MEDICAL / LIFESTYLE RELATED INFORMATION**

**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-EXISTING 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 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	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)

**DECLARATION**

- 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.
- 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.
- 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.
- 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.
- 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)

Signature of the Proposer/Authorized Representative\* : \_\_\_\_\_  
(On behalf of all the persons to be insured under the Policy)

Place :

\*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 ☐ (☒ Tick whichever is applicable)

Cheque / Demand Draft No. / Authorization ID :

Payment Amount (₹) :

Premium Amount (₹) :

Date :

Bank Name :

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 Cheque/Demand Draft, the instrument should be drawn in favour 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 computerized receipt against the deposited cash against your Proposal. Any claim without computerized receipt against the deposited 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)

**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.

**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 Declarant/Authorized Representative\* : \_\_\_\_\_

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

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## ANNEXURE – I: OPTIONAL COVERS

Optional Cover – 1 : 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 – 11 : Annual Health checkup : ☐ Yes ☐ No

Optional Benefit – 12 : Be-Fit Benefit : ☐ Yes ☐ No

Optional Benefit – 13 : Wellness Benefit : ☐ Yes ☐ No

Optional Benefit – 14 : Air Ambulance Cover : ☐ Yes ☐ No

Optional Benefit – 15 : Women Care benefit : ☐ Yes ☐ No

Optional Benefit – 16 : 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

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

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