

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"/>			
Details of Optional Cover(s) as per Annexure - I					
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

Insured 1 : Name : Mr./Ms./Mrs.					
Height	cms	Marital Status	Date of Birth	DDMMYYYY	Annual Income (In Lacs) : ₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	
Do you have ABHA No.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please provide ABHA Number (Optional)		
If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>					
Insured 2 : Name : Mr./Ms./Mrs.					
Height	cms	Marital Status	Date of Birth	DDMMYYYY	Annual Income (In Lacs) : ₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	
Do you have ABHA No.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please provide ABHA Number (Optional)		
If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>					
Insured 3 : Name : Mr./Ms./Mrs.					
Height	cms	Marital Status	Date of Birth	DDMMYYYY	Annual Income (In Lacs) : ₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	
Do you have ABHA No.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please provide ABHA Number (Optional)		
If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>					
Insured 4 : Name : Mr./Ms./Mrs.					
Height	cms	Marital Status	Date of Birth	DDMMYYYY	Annual Income (In Lacs) : ₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	
Do you have ABHA No.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please provide ABHA Number (Optional)		
If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>					
Insured 5 : Name : Mr./Ms./Mrs.					
Height	cms	Marital Status	Date of Birth	DDMMYYYY	Annual Income (In Lacs) : ₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	
Do you have ABHA No.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please provide ABHA Number (Optional)		
If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>					
Insured 6 : Name : Mr./Ms./Mrs.					
Height	cms	Marital Status	Date of Birth	DDMMYYYY	Annual Income (In Lacs) : ₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>
Nominee (Relationship with Insured) :		Relationship with Proposer :		City of Residence :	
Do you have ABHA No.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please provide ABHA Number (Optional)		
If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>					

*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.

MEDICAL / LIFESTYLE RELATED INFORMATION

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
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	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____
2. Any heart disease or disorder, chest pain or discomfort, irregular heartbeats, palpitations or heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____
3. Hypertension / High Blood Pressure(BP)/ High Cholesterol/Any other Lipid disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____
4. Asthma / Tuberculosis (TB) / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease?	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____
5. Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pituitary tumor/ disease or any other disorder of Endocrine system?	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____
6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____
7. Motor Neuron Disease/ Muscular dystrophies/ Myasthenia Gravis/ Demyelinating disease or any other disease of Neuromuscular system (muscles and/or nervous system)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____

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: CHIHLIP23128V012223 IRDAI Registration No. - 148

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?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
11. HIV/SLE/ Rheumatoid Arthritis / Scleroderma / Sarcoidosis/ Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin.	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
12. Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses)?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N 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?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N 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.	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> 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.

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.

Date : / / (DD/MM/YYYY)

Signature of the Proposer : _____

Place :

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

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

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)

Signature of the Proposer : _____

Place :

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

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.

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:

Aadhar Card No.:

PAN Card No.:

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 :

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: CHIHLIP23128V012223 IRDAI Registration No. - 148

ADDENDUM – VERNACULAR DECLARATION

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)

ANNEXURE – I: OPTIONAL COVERS

- Optional Cover – 1 : Smart Select: Yes No
- Optional Cover – 2 : Room Rent Modification : Yes No
- Optional Cover – 3 : PED Wait Period Modification : Yes No
- Optional Cover – 4 : Named Ailment Wait Period Modification : Yes No
- Optional Cover – 5 : Instant Cover : Yes No
- Optional Cover – 6 : Deductible : Yes No
(If yes, then please mention the deductible amount opted) :
- Optional Cover – 7 : Co-Payment : Yes No
(If yes, then please mention the Co-pay %) :
- Optional Cover – 8 : New Born cover : Yes No
- Optional Cover – 9 : Plus Benefit : Yes No
- Optional Cover – 10 : Cumulative Bonus Super : Yes No
- Optional Cover – 11 : Annual Health checkup : Yes No
- Optional Cover – 12 : Be-Fit Benefit : Yes No
- Optional Cover – 13 : Wellness Benefit : Yes No
- Optional Cover – 14 : Air Ambulance Cover : Yes No
- Optional Cover – 15 : Women Care benefit : Yes No
- Optional Cover – 16 : Mental Health wellbeing : Yes No
- Optional Cover – 17 : Claim Shield : 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. 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.

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