

Corona Kavach Policy - Care Health Insurance

Proposal Form

URN: CHIL / R / HE / 090 / 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.

4. The proposed policyholder will be referred to in this Proposal Form as	"Propo	oser'', ''Y	ou" or "Yo	our".																					
PROPOSER DETAILS																									
Name : (Mr./Ms./Mrs.)																									
		(First 1	Name)							(Middl	e Name	e)								(Last	Nam	ne)			
Correspondence Address :																									
Locality:										Cit	у:														
Pin Code :							Stat	e :																	
Landmark:																									
Permanent Address : If same as above, please tick here																									
Locality:										Cit	y:														
Pin Code :							Stat	e:			T														
Telephone:										Mo	obile*:														
Alternate No.:																									
Email:																									
*The registered mobile number will be enrolled for	Wha	tsApp	notific	ations r	elate	ed to	your	Care	e Hea	alth Ins	urance	Poli	су [D											
Date of Birth / Incorporation (in case Proposer is an	entit	y) [MM		Y	7						Gende	er:			Ma	le		Fei	male	: [Othe	ers	
Marital Status : Single	Mar	ried				Di	vorce	d			Wid	dow(er)			Se	para	ated	T						
Mother's Name :			$\overline{}$										Ť						Ė						
PAN Number:								Nati	ionali	ity :															_
Form 60 (only in case the customer does not have PAN no.)	\pm	Yes			1	Vo					er(last	4 di	gits):		X	X	X	X	X	X	X	X			
Health Care Worker Yes No Please share the following for authentication purpose:																									
Proof of Identity (POI) (Tickwhichever																									
PAN Aadhaar Passport	Dr	rivingl	icense		Vote	er ID (Card																		
Letter from a recognized public authority or public serv	vant	/erifyii	ng the ic	dentitya	and re	eside	nce of	the	Propo	oser															
Proof of Address (POA) (Tie	ckwł	nichev	er is app	olicable))																				
Electricity bill (not older than 3 months)	Aadl	haar [Pas	sspor	^t			Ra	ation C	Card				Dr	iving	g Lice	ense							
Telephone Bill (not older than 3 months)	Bank	(Acco	unt Stat	tement	(not	olde	rthan	3 mc	onths])															
Letter from a recognized public authority or public serv	vant \	verifyii	ngtheic	dentitya	and re	eside	nce of	the	Propo	oser															
Would you like to opt for Electronic Policy Issuance thro If you have an elA, please provide following details:	ough	an e-Ir	nsuranc	e Accoi	unt (e	elA) d	of an Ir	nsura	ance F	Reposi	tory?			Ye	:S					No)				
I) Name of Insurance Repository:																									
ii) elANo:																									
iii) Name as appearing in eIA:																									
If you do not have an eIA, would you like to open an account Yes, choose any one Insurance Repository:	ount?	1		,	Yes				1	No															
□ NDML−NSDL Data Management Limited							☐ CAMSRep-CAMS Repository Services Limited																		
☐ Karvy Insurance Repository Limited						☐ CIRL-Central Insurance Repository Limited (CDSL)																			
Help us preserve the environment by opting to receive	polic	y relat	ted info	rmation	n in sc	oft co	py/via	.ema	ail only	y:			Yes						No						

POLICY DE	TAILS															
Sum Insured (in R	Rs.):															
Tenure:			3 a	and half months	; 🗌	6 and half n	nonths 🗌	9 ar	nd half mo	onths 🗌						
Cover Type:			Individ	ual 🗌	Floater											
NOMINEE	DETAI	LS														
			Non	ninee Name				Date of B	Birth (DE	D/MM/YYYY)	R	elationsh	nip with	Prop	oser	
*If the Nominee is of .	Ago 19 von	c or loss Namo of	Annointoo	and Polationship wit	th Minor											
The Northhee is of .	rige to year:	s or less, indiffe of a		intee Name	urrimor.			Date of E	Birth (DE	D/MM/YYYY)		Relation	ship wi	th Mi	nor	
	6.1. 0			B											_	
Nominee for all the oth	ner person(s	ser any payment du) proposed to be ins	ie under the sured shall b	e Policy shall become e the Proposer hims	e payable to th self.	e Nominee proposed i	n this Proposal Fori	n. The receip	t of the pro	ceeds by the Non	inee would t	oe sufficient	discharg	e of the	Com	pany. The
DETAILS O	F THE	PROPOS	ED TC	BE INSU	RED INC	CLUDING PF	ROPOSER									
Insured I : Na	me : Mr/l	Ms /Mrs														
Height	cms	Marital Status	s			Date of Birth	DDM	M Y Y	/ Y Y	Annual Inc	ome (la Lacci) : ₹				
Weight	kg	Gender	Male [Female		Others			naar/PAN	No. (Optiona		, ,				
Nominee (Relationsh				Relationship			City	of Resider				If PEP*	: Yes		No	$\overline{\Box}$
Occupation																
Do you have AB	HA No.	Yes N	lo 🗌	If Yes, please p	provide AB	HA Number (O	otional)									\vdash
Insured 2 : Na	me : Mr./ľ	Ms./Mrs.													\top	+
Height	cms	Marital Status	s			Date of Birth	DDM	MYN	YY	Annual Inc	ome (In Lacsi): ₹				
Weight	kg	Gender	Male [Female		Others		Aadh	naar/PAN	No. (Optiona	l)					
Nominee (Relationsh	nip with Insured):		Relationship	with Propo	ser:	City	of Resider	nce :			If PEP*	: Yes		No	
Occupation																
Do you have AB	HA No.	Yes N	lo 🗌	If Yes, please p	provide AB	HA Number (O	otional)									
Insured 3: Na	me : Mr./l	Ms./Mrs.														
Height	cms	Marital Status	S			Date of Birth	DLM	1 Y Y	YY	Annual Inc	ome (In Lacs) : ₹				
Weight	kg	Gender	Male [Female		Others 🗌		Aadh	naar/PAN	No. (Optiona	l)					
Nominee (Relationsh	nip with Insured):		Relationship	with Propo	ser:	City	of Resider	ice :			If PEP*	: Yes		No	
Occupation																
Do you have AB	HA No.	Yes N	lo 🗌	If Yes, please p	provide AB	HA Number (O	otional)									
Insured 4 : Na	me : Mr./ľ	Ms./Mrs.		4												
Height	cms	Marital Status	S			Date of Birth	DDM	YY	YY	Annual Inc	ome (In Lacs) : ₹				
Weight	kg	Gender	Male	Female		Others		Aadh	naar/PAN	No. (Optiona	l)					
Nominee (Relationsh	nip with Insured):		Relationship	with Propo	ser:	City	of Resider	nce :			If PEP*	: Yes	: 📙	No	4
Occupation A.P.	I IA NIa	V D		If Vac places r	anavida AD	I I A N I una la aua (Ou	ational)								_	
Do you have AB			lo 📗	ii ies, piease į	orovide Ab	HA Number (Op	Juonai)								_	
Insured 5 : Na						Date of Birth	DDM	M Y Y	/ \/ \/	A						
Height Weight	cms kg	Marital Status Gender	Male [Female		Others			2225/DAN	Annual Inco) : ₹			+	+
Nominee (Relationsh	0		Thale _	Relationship			City	of Resider		ч тчо. (Ориопа	1)	If PEP*	· You		No	$\dashv \dashv$
Occupation	iip with insured			Telationship (With Fropo	SCI .	City	Ji Nesidei	ice .			11 1 1	. 163		110	$\dashv \dashv$
Do you have AB	HA No.	Yes N	lo 🗆	If Yes, please r	orovide AB	HA Number (O	otional)									+
Insured 6 : Na															+	
Height	cms	Marital Status	S			Date of Birth	DDM	M Y Y	/ Y Y	Annual Inc	ome (In Lacs) : ₹			+	
Weight		Gender	Male	Female		Others		Aadh	naar/PAN	No. (Optiona		, , , , , , , , , , , , , , , , , , ,				
Nominee (Relationsh	nip with Insured):		Relationship v	with Propo	ser:	City	of Resider		<u> </u>		If PEP*	: Yes		No	\exists
Occupation			471													
Do you have AB	HA No.	Yes N	lo 🗌	If Yes, please p	provide AB	HA Number (O	otional)									
*Have you ever b	een entru:	sted with prom	inent pub	blic functions, for	rexample. H	Heads of State or o	of Governmen	t. senior	politicians	s. senior gove	nment. iu	udicial or	militar	v off	icials.	senior
executives of sta								,		,	. ,			,	,	
MEDICAL /	LIFEC	TVI E DEL	ATER	INICORMA	TION											
MEDICAL /	LIFES	TYLE KEL	ATED	INFORMA	TION											
Particulars						Insured I	Insured 2	Ins	ured 3	Insure	d 4	Insure	1 5	In	sure	d 6
I. Are you so Mellitus/Hyo	uffering/opertension	diagnosed/und on/Chronic I	der tre	atment for sease/Chronic	Diabetes kidnev	Y	YN	Y	N	Y	N	Υ	N	Y		N
disease/Chro	nic liver d	isease?				Since	Since	Sino	ce	Since		Since		Sin	ce	
2. Are you suff	ering/diag	nosed/treated	l/under t	reatment for a	any other	YN	YN	Y		Y	N	Y	N	Y	1	N
condition not	mention	ed above? If yes	s please p	rovide details	,	Since	Since	Sind		Since		Since		Sin	_	

LIFESTYLE RELATED DECLARATION													
Particulars	Insu	red I	Insu	ed 2	Insur	ed 3	Insu	red 4	Insu	red 5	Insu	ıred 6	Ī
Have you travelled to any containment zone/city/district/country in las days where travel is restricted by any Government Authority	t 30	N	Y	N	Y	N	Y	N	Y	N	Y	N	
Have you diagnosed or developed any symptoms related to COVID I last 30 days.	9 in Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	
Any of your family member residing with you has been suspected diagnosed or have developed any symptoms related to the COVID 19 (self or mandated guarantine or self-isolation?	d or or is	N	Y	N	Y	N	Y	N	Y	N	Y	N	
Status of the Insured as per Arogya Setu or any Govt authorized trac	king												
Note: The Company shall reject Your proposal and refund the premium amo	ount in case of	incomplete	eness or a	ny discrep	ancy highli	ghted or a	any other	reason.					_
ADDITIONAL INFORMATION (IF YOUR ANSW INSURED ARE SUFFERING FROM ANY OTHER													
INSURED ARE SOFFERING FROM ANT OTHER	r ne exis	oi i NG	DISLA	SE VVI	псн і	3 NO I	MISK	IIONE	D IN I	ne At	JOVE	LISI)	
													_
ATTENDING BUNGLEANIC DETAIL C													
ATTENDING PHYSICIAN'S DETAILS													
Name of Family Physician : (First Name)			(Mic	Idle Name					(Last Nan	ne)		+
Contact Number :		E	mail :										
DETAILS OF PREVIOUS OR EXISTING HEALTH	INSUR	ANCE											
Please fill the following details with respect to health insurance proportion	osals/policies	with the	Company	or any o	other insu	urance co	ompanies						
Details Have any of the person(s) to be insured ever filed a claim with their	Insu	ired I	Insu	red 2	Insur			red 4		red 5		ıred 6	
current/ previous insurer? If Yes, please provide details on a separate s	heet	N				N	Y	N	LY LY		Y	N	_
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition	(s)?	N	Y	N	L Y	N	Y	N	Y	N	Y	N	
Is any of the person(s) proposed for insurance covered under any other			Y	N	Y	N	Y	N	Y	N	Y	N	
health insurance policy with the Company or any other Company with break?	out Since	**************************************	Since (DD/M)		Since.	 M/YYYY)	Since.	 M/YYYY)	Since.	 M/YYYY)	Since	E	
DECLARATION	(DD/I	1111)	(DD/I1		(DD/MI	*1/1111)	(DD/M)	*1// 1 1 1 1)	(DD/M	-1/1111)	(DD/II)	11-17	
a. I hereby declare, on my behalf and on behalf of all persons propos						vers and i	or partion	culars give	en by me	are true	and com	plete in a	ıll
respects to the best of my knowledge and that I am authorized to pub. I understand that the information provided by me will form the base.						proved u	ınderwrit	ing policy	of the in:	surer and	l that the	policy w	ill
come into force only after full payment of the premium chargeable c. I further declare that I will notify in writing any change occurring i						•		,					
before communication of the risk acceptance by the company. d. I declare that I consent to the company seeking medical informatio		_											
any past or present employer concerning anything which affects the whom an application for insurance on the person to be insu	he physical c	or mental l	health of	the perso	on to be i	insured /	proposei	rand see	king infor	mation f	rom any	Insurer t	0
e. lauthorize the company to share information pertaining to my propor claims settlement and with any Governmental and / or Regulation	oosal includin												
Date: // / DD/MM/YYY)	y auti ioi ity.			Signature	e of the Pi	roposer	:						
Place :													
PREMIUM PAYMENT INFORMATION									,,				
Payment By: Cash / Cheque / Demand Draft / Card /ECS (NACH	IV/Reward Po	oints/\/\alla	et/Any of	her mod	a (Strika	out which	chever is	not appli	cable)				
Premium Amount (INR):	i)/Neward FC	DILICS/ V Valle	et/Arry or	THE THOC	e (Strike	Out Will	liever is	пос арріі	Cable)				+
Cheque / Demand Draft No. / Authorization ID:													7
Payment Amount (₹):													
Date : Bank No	ame :												
													_

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" and the standing instruction form available at our branches are payment through Cheque / Demand Draft, the instrument should be drawn in favour of "Care Health Insurance Limited" and the standing instruction form available at our branches are payment through Cheque / Demand Draft, the instrument should be drawn in favour of "Care Health Insurance Limited" and the standing instruction form available at our branches are payment through Cheque / Demand Draft, the instrument should be drawn in favour of "Care Health Insurance Limited" and the standing instruction form available at our branches are payment through Cheque / Demand Draft, the instrument should be drawn in favour of "Care Health Insurance Limited" and the standing in the s

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 & R	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											
declare that the information given above is true and correct. 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)	Signatu	re 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) 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											
			bate as may be allowed in accordance with the published prospectuses or								
Any person making default in complying with the provisions of	this section shall be liable for a penalty which	ch 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 Branch Details											
RHIL 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: Aadhaar Card No.:	s of "Point of Sales" Person:	PAN Card No.:									
DECLARATION FOR AGENTS											
all the contents of this Proposal Form, including the nature of the qui or any details sought herein will form basis of the Contract of statement(s)/information/response(s) is/are contained in this Propositems and Conditions and furthermore, if there has been a non-disforfeited to the Company. License No. (Advisor/Corporate Agent/Broker/Relationship Officer	uestions contained in this Proposal Form to to of Insurance between the Company and ossal Form/including addendum(s), affidavits, s sciosure of any material fact, the policy issued r):	the Proposer including statement(s), information and response(s): the Proposer, if this proposal is accepted by the Company for statements, submissions, furnished/to be furnished, the Company	of the Broker/Relationship Officer, do hereby declare that I have explained submitted by him/her in this Proposal Form to questions contained herein or issuance of the Policy. I have further explained that if any untrue shall have the right to vary the benefits which may be payable as per Policy Company as null and void and all premiums paid under the Policy may be								
Date:	DD/MM/YYYY)	Signature:									
SP Name :		SP Code:									
ADDENDUM – VERNACULAR DE	CLARATION										
son/daughter of		resident of	declare that I have read out and fully								
explained the contents of the Proposal Form and all of imperative for the Proposer to avail the insurance from information provided by the Proposer. The replies have all Date:	other accompanying documents in _ n the Company . The contents and in	language to the mport of the proposal have been fully understood by l	Proposer which is a language understood by him/her and is nim/her and the replies have been recorded according to the								
Place:											
Name of the Declarant :											
Signature of the Declarant :											
(On behalf of all the Proposed to be Insured under the Policy)											
ACKNOWLEDGEMENT FOR PRO	POSAL										
Please retain this counterfoil for your records			(On behalf of Care Health Insurance Limited)								
We acknowledge the receipt of payment of											
	at the proposal amount is received and	nd Policy Start Date. The validity of this receipt is subject	nt to acceptance of risk or commencement of the Policy. The to realization of the proposal amount. Acceptance of proposal								
, , , ,	, сотприскот горозан онт, ргениин		, ,								
Proposal No.:Name of the Representative :		Signature of the Repres	entative:								
Insurance is a subject matter of solicitation. IRDAI Registration No.											
	re advised to do so only at the nearest		d Bank branch, and we insist you to please ask for computerize								