

corona kavach

Proposal Form

JRN: CHIL / R / HE / 090 / 22-23	JRN: CHII	_/R/I	HE / 0	90 / 22	2-23
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Proposal No.:__

- To be filled in by the Proposer in CAPITAL LETTERS only.
- To be filled in by the Proposer in CAPITAL LET LENs 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".

PROPOSED PETALLS																											
PROPOSER DETAILS																											
Name : (Mr/Ms./Mrs.)																		T	4								
		(First N	lame)							(Mido	lle Name	e)									Last	Nami	e)				
Correspondence Address :																									V		
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*The registered mobile number will be enrolled for	Wha	tsApp	notific	ations i	relate	ed to	your	Care	Hea	alth In:	surance	Pol	icy	O													
Date of Birth / Incorporation (in case Proposer is an			IDI	ММ	Y	Y	Y	7					Geno				~	1ale	Г		Fer	nale			Othe	re	
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Form 60 (only in case the customer does not have PAN no.) :	<u>Ш</u>	Yes				No		_			oer(last				lo. for Au	rthentic	ation of	my Aa	dhaar	Details)	\wedge	\wedge	\wedge				
Health Care Worker Yes No																											
CKYC:					Ţ																						
Please share the following for authentication purpose) :																										
Proof of Identity (POI) (Tick whichever	·is app	olicable)																								
PAN Aadhaar Passport	Dr	rivingLi	cense		Vote	erID(Card																				
Letter from a recognized public authority or public serious for all the contractions are consistent on the contraction of the cont	vant v	erifyin	gtheic	dentity	and re	esider	nce of	fthe F	ropo	oser																	
Proof of Address (POA)	ickwh	nicheve	r is app	olicable)																						
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Telephone Bill (not older than 3 months)	Bank	Accou	ınt Stat	tement	t (not	older	than	3 mo	nths	s)																	
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I) Name of Insurance Repository:																											
ii) elANo:																											
iii) Name as appearing in elA:																											
If you do not have an eIA, would you like to open an acc	ount?				Yes				1	No																	
If Yes, choose any one Insurance Repository:																											
□ NDML−NSDL Data Management Limited											CAMSI																_
☐ Karvy Insurance Repository Limited								C	IRL-	-Centr	al Insura	ance	Rep	osit	ory L	imi	ted (CE	DSL)							
Help us preserve the environment by opting to receive	e polic	y relate	ed info	rmatio	n in sc	oft cop	oy/via	emai	lonh	ly:			Υe	es					1	Vo							

POLICY DE	TAILS																											
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Bank Name																												
Name of the	e Account	Holder																_	_									
Appointee De	tails (Only v	where the Non	ninee a	ge is le	ss than	l 8 year	s)																					
Appointee	Name	Age			Mob	ile No.						Er	mail	ID							R	elatio	onshi	ip wi	th Mi	nor		
In event of the de Beneficiary would																							cee	ds by	the	Vom	ninee	/
		_																										
In case you want	to provide	e more than 3	nomir	nees, p	olease e	ither p	provide	a sep	parate app	ication	or ac	dd the	no	minee	via c	our w	ebsite	e thn	ough	Endo	orsem	ent.						
DETAILS O	FTHE	PROPOS	ED T	ОВ	EINS	SURE	D IN	ICL	UDING	PRC	PO	SER																
Insured I: Nar	me : Mr./M	1s./Mrs.																										
Height	cms	Marital Statu	S					1	Date of Bir	th		M	M	Y	Y \	Y	Ar	nnual	Inco	ome (I	n Lacs) :	₹						
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Occupation																												
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Insured 5 : Name : Mr./Ms./Mrs.																			
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Occupation						Ļ	Щ	\perp				Щ			_				
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Insured 6 : Name : Mr/Ms./Mrs.						4 >									4				
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Occupation Do you have ABHA No. Yes No If Yes, please provide A	BHA Nu	mber (C	Option	nal)		\perp		\Box			_			_	\dashv			_	
*Have you ever been entrusted with prominent public functions, forexample,					nment	COL	nior r	olitic	ianc	canic	or go	vernm	ent	iudici:	al or	milit	my off	iciale	cani
executives of state owned corporations or important political party officials.	i icads oi	State of	01 0	JOVCI	HILICH	, 301	illoi p	Olltic	.iai 13,	SCHIC	n go	VCITIIII	CIII,	udici	ai Oi	1111110	и у Оп	iciais	, acrii
MEDICAL / LIFESTYLE RELATED INFORMATION													4						
MEDICAL / LIFESTYLE RELATED INFORMATION											_							4	
Particulars	Insu	red I	Ir	ısur	ed 2		Insu	ired	3		Insu	red 4		Ins	irec	d 5	In	sure	ed 6
 Are you suffering/diagnosed/under treatment for Diabetes Mellitus/Hypertension/Chronic Lung disease/Chronic kidney 		N		Y	N		Υ		N		Y	N		Y		N	Υ		N
disease/Chronic liver disease?	Since		Si	ince_			Since	e		5	ince_			Sinc	e		Sin	ce_	
2. Are you suffering/diagnosed/treated/under treatment for any other	. Y	N		Y	N		Υ		N		Y	N		Y		N	Y		N
condition not mentioned above? If yes please provide details	Since.		Si	ince_			Since	e		5	ince_			Sinc	e		Sin	ce_	_
Note: The Company shall reject Your proposal and refund the premium amount i	in case of i	ncomplet	eness	or an	y discre	epan	cy high	nlighte	ed or	any c	ther r	eason.							
LIFESTYLE RELATED DECLARATION																			
Particulars	Insu	red I	Ir	nsur	ed 2		Insu	ıred	3		Insu	red 4		Ins	ured	d 5	ln	sure	ed 6
Have you travelled to any containment zone/city/district/country in last 30						7													
days where travel is restricted by any Government Authority	Y	N	E	Y	N		Y		Ν		Υ	N		Υ		Ν	Υ		Ν
		-				+		_	_										
Have you diagnosed or developed any symptoms related to COVID 19 in last 30 days.	Y	N	1 [Y	N		Y		N		Υ	Ν		Υ		Ν	Y		Ν
,										+									
Any of your family member residing with you has been suspected or diagnosed or have developed any symptoms related to the COVID 19 or is		N	1 F	Y	N		Y		Ν		Y	N		Υ		N	Y]	N
self or mandated quarantine or self-isolation? Status of the Insured as per Arogya Setu or any Govt authorized tracking						+													
Status of the insured as per Arrogya Setu of any Govt authorized tracking																			
Note: The Company shall reject Your proposal and refund the premium amount in	case of inc	ompleter	ness or	any	discrep	ancy	highlig	ghted	or a	ny oth	er rea	ason.							
ADDITIONAL INFORMATION (IF YOUR ANSWER	IS 'YE	S' TO	AN	r O	FTH	E A	ABO	VΕ	οι	JEST	ГЮ	NS C	DR 1	HE	PR	OPO	DSEL	Т	ОВІ
INSURED ARE SUFFERING FROM ANY OTHER PR																			
ATTENDING PHYSICIAN'S DETAILS																			
Name of Family Physician :																			
(First Name)						1iddl	le Nam	ne)							(La	st Nan) (P)		
Contact Number :		T F	Email :	:	- (1	T	IC I Vali	T			_				(La	DC I Vali			
DETAILS OF PREVIOUS OR EXISTING HEALTH IN	VICI ID V																		
			<u></u>																
Please fill the following details with respect to health insurance proposals Details	-	with the			or an	y oti	ner in Inst					red 4		Inc	ure	45	In	SIIV	ed 6
Have any of the person(s) to be insured ever filed a claim with their								1 -							7 [
current/ previous insurer? If Yes, please provide details on a separate sheet	t Y	N	<u> </u>	Y	N	4	Y		N		Y	N	_	Y		N			N
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	Y	Ν		Υ	Ν		Y		Ν		Υ	Ν		Υ		Ν			Ν
	Y	N		Υ	N	\top	Y		N		Y	N	\top	Y		N		/	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				ince			Since				Since			Sinc			Sin		
break?	'	M/YYYY)			1/YYY)		(DD/I		 YYY)			1/1/1/		(DD/I					YYYY)
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a. I hereby declare, on my behalf and on behalf respects to the best of my knowledge and that																		
								wers an	d/or	partic	ulars	given	by me	are tr	ue and	d comp	olete in a	all
b. I understand that the information provided by								pprove	d unde	rwriti	ng po	licy of	the in	surer a	and th	at the	oolicy w	ill
come into force only after full payment of the	premium char	rgeable.			, ,	,					01	,					,	
c. I further declare that I will notify in writing arbefore communication of the risk acceptance			the occu	ipation c	r general I	nealth of th	ne life to t	oe insur	ed / pr	opose	er afte	er the	propo	osal ha	s beei	n subn	ntted bu	Jt
d. I declare that I consent to the company seekir any past or present employer concerning an whom an application for insurance on the	ything which a	affects th	e physica	al or mer	ntal health	of the per	son to be	insured	d/pro	poser	and s	eekin	g infor	matio	n fror	n any I	nsurer t	0
e. lauthorize the company to share information	pertaining to	my propo	sal inclu	dingther	medical red	ords of the	e Insured/	'Propos	erfor	the so	o le pur	pose						
or claims settlement and with any Government	ntaland/orke	0 /		,	0 0	and/orsna poser/Aut	0 /				gnAB	HA.						
Date: / /](DD/MM/111	11)		ngi iatur e	ortherro			'										_
Place:					**	`	alf of all the						,,					
					*(Only Applicabl	e wnere pro	ooser is a p	erson w	ith a disa	bility ar	id who i	nas appo	inted an a	authoriz	red repre	sentative	
PREMIUM PAYMENT INFORMAT	ION																	
Payment By: Cash / Cheque / Demand Draft	/ Card /ECS ((NACH)/	'Reward	Points/V	Vallet/Any	other mo	de (Strik	e out w	hichev	er is r	not ap	plicat	ole)					
Premium Amount (INR):																		
Cheque / Demand Draft No. / Authorization ID):													4				
Payment Amount (₹):																		
Date:	F	Bank Nar	ne :							Щ			Ų		Щ	4		╝
If ECS is selected, please submit the standing instruction form availa In case of payment through Cheque / Demand Draft, the instrument			"Care Heal	th Insurance	Limited"													
Note: Should you choose to pay premium by cash, you are advised	d to do so only at t	he nearest (Care Health	Insurance L	imited branch	or any autho	rized Bank b	ranch, and	we insis	t you to	please ;	ask for d	ompute	rize rece	eipt agair	nst the d	eposited ca	ash
against your Proposal. Any claim without computerized receipt against	nst the deposited o	cash will not I	oe admitted	l.														
NEFT DETAILS (FOR CLAIMS & F	REFUND I	PURPO	OSES)															
Account Number:						IFSC Cod	le:											
Bank Name :						Bank Brai	nch Nam	e:										
Name of the Account Holder:																		
Note: Please submit copy of cancelled cheque along with Propo																		
I declare that the information given above is true and correct. I he responsible for non-credit/non-payment of payout or refund, if a	ereby authorize (ny, due to any rea	Lare Health Ison includir	Insurance I ng but not li	imited to d imited to in	lirectly credit correct/incor	payout/refund oplete informa	d, if any, to t ation. Care I	ne above i Health Insi	mention urance L	ed accor imited r	unt and eserve	l I shall s right t	not hold o use ar	l Care H ny altern	lealth In ative pa	isurance iyout opt	Limited ion such a	S
cheque/demand draft in spite of providing above information.																		
Date: / / /	(DD/MM/YYYY	()	Sign	nature of the	e Proposer / A	uthorized Rep	resentative ³)a la a la a l	Co Collabo					na Dalia	۸		-
Place:														underth				
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STATUTORY WARNING					*(Only Applicabl	e where pro	50301 IS 4 P	ersorrw	ith a disa	DIIILY AI	id who r	nas appoi	inted an a	authoriz	ed repre	sentative	
Prohibition of Rebates					*(Only Applicabl	e where pro	3030 IS 4 P	ersonw	ith a disa	DIIILY AI	id who r	nas appoi	inted an a	authoriz	red repre	sentative	
Prohibition of Rebates (Under Section 41 of Insurance Act 1938) I. No person shall allow or offer to allow, either directly or indire					ew or continue	e an insurance	in respect of	any kind o	f risk rela	ting to liv	ves or p	roperty	r in India,	any reba	te of the	e whole (r part of th	
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Prohibition of Rebates (Under Section 41 of Insurance Act 1938) 1. No person shall allow or offer to allow, either directly or indirecommission payable or any rebate of the premium shown on	the policy, nor shall	I any person	taking out o	or renewing	ew or continue or continuing	e an insurance a policy accept	in respect of	any kind o	f risk rela	ting to liv	ves or p	roperty	r in India,	any reba	te of the	e whole (r part of th	
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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: RHIHLIP21087V012021 IRDAI Registration No. - 148