

# Domestic Staff Insurance Add-On

Proposal No.:\_\_\_

### **Proposal Form** URN: CHIL/R/HE/083/22-23

- 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 Forn	n as ''ì	You"	or "Your	".	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	011300			aci ici	a aocan	i ici ici	.0	Jul 10		Поро	Jul 1 0															
FOR OFFICE USE ONLY																															
Intermediary Details																															
Intermediary Code :										Inte	rme	diary	y Na	ame	::					1											
Intermediary RM Code :										Brai	nch (	Cod	e :						1												
Customer Acc No. :																															
Care Health Insurance Branch Details																															
CHIL RM Name :																							4								
Branch Code :								Clie	ent l	ID :											Re	ceip	t ID	1							
<b>Details of 'Point of Sales' Person :</b> (To be fi	illed	in if	the P	olicy	is s	our	ed :	thro	ugh	'Poin	t of	Sales	s' Pe	erso	n)													,			
Please furnish at least one of the following details	of "	Poir	nt of S	ales'	' Pe	rson	:									abla															
Aadhaar Card No.:												F		PA	NC	ard	No.														
PROPOSER DETAILS											í				i			ì	ì												
Name : (Mr./Ms./Mrs.)				T	Т				_		V	T	T		4					₹						$\overline{}$	$\overline{}$	$\equiv$	$\equiv$		
Name (minimis.)			(First N	Jame	2)		_				4	4	/M	liddle	e Nar	ne)					Y				(1 20	st Nar					
Proposer Insurance details with CHI:	N		e of Ba			fuct	.					7		lideli	CINAI	110)	Ras	se Po	licv	Nu	mhe	r'			(Las	T	T	Т	Т		Т
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Locality:	Н			+	+	$\dashv$					7			Cit	v .			$\dashv$								+	$\vdash$	+			
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Landmark:												$\top$	7		$\top$											+	$\vdash$	$\vdash$			
Permanent Address :					$\top$								T																		
If same as above, please tick here	П			1																						$\top$			Т		
Locality:					7									Cit	у:																
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Telephone :														Mc	bile*	:															
Alternate No.:																															
Email:																							L				L				
*The registered mobile number will be enrolled for	or V	Vha	tsApp	noti	ifica	tions	s rel	atec	d to	your	Care	е Не	alth	Inst	urand	e P	olicy	<u>C</u>													
Date of Birth / Incorporation (in case Proposer is	an e	entit	zy) : [	$\square$			M	Y	Y	Y		G	end	er:	~	1ale						Fen	nale				0	ther	s		
Marital Status : Single		Mar	ried						Di	vorce	d [					\	Vid	ow(e	er)						Se	parat	:ed				
Mother's Name:				T																								T			
PAN Number:					$\top$						Nat	iona	lity	:																	
Form 60 (only in case the customer does not have PAN no.) :			Yes					No							er(la					$\times$	X	X	X	X	×	$\times$	X				
(By signing the Proposal form I give my consent for using my Aadhaar No. for Authentication of my Aadhaar Details)  Please share the following for authentication purpose:																															
Proof of Identity (POI) ( Tick whichever	erisa	appl	icable)																												
PAN Aadhaar Passport Driving License Voter ID Card																															
Letter from a recognized public authority or public se	ervar	nt∨∈	erifying	gthe	ideı	ntity	and	resid	den	ce of t	:he P	ropo	oser																		
Proof of Address (POA)	Tick <sup>,</sup>	whi	chever	ris ap	plic	cable	:)																								
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 Pc If you have an eIA, please provide follow	,		ough an e	-Insuran	се Ассоі	ınt (eIA)	of an Ir	nsuranc	e Reposito	ory?		Ye	es			Ю			
I) Name of Insurance Repository:																			
ii) elANo:																			
iii) Name as appearing in eIA:																			
If you do not have an eIA, would you lik If Yes, choose any one Insurance Repo		en an acco	ount?		Yes			N	0										
☐ CAMSRep−CAMSInsurance F	Reposito	ory & Ser	vices						ML-NSD	DL Data N	Manager	ment	Limited						
☐ SHCIL—Stock Holding Corpor	ation of	India Lim	ited					KAR'	VY										
☐ CIRL—Central Insurance Repo	sitory L	imited																	
Help us preserve the environment by	optingt	o receive	policy rel	ated info	rmation	in soft c	opy/via	.email o	nly:		Yes			j	No				
POLICY DETAILS																			
Proposed Policy Period Start Date:	DE	MM	1 Y Y	YY	Plan C	Opted:													
Sum Insured (in Rs.):																			
Cover Type:		Individua		☐ Flo	ater		Tei	nure:			Year		2Ye	ar		3 Year			
Are you applying for portability?		Yes			)	(If ye	s, please	e fill in th	ne separat	e Portab	oility For	m)							
NOMINEE DETAILS OF		NGLIB	ED																
NOMINEE DETAILS OF	IHE																		
		Nomine	e Name						Da	ate of Bi	rth (DD	)/MM	/YYYY)		Relatio	onship wi	th Insu	red	
*Only where the Nominee is of Age 18 years o	r less:									$\overline{}$						-			
						Арро	ointee N	Vame											
La contraction of the language	-lll l		4l N l '				Li. D 4	ul Fama 7	F1	Calina	a da la cala	Nicoli			at d'a di a car	- C+1 C	т.	- NIi-	6
In event of the death of the Insured any Payment all the other person(s) proposed to be insured sha	all be the l	nsured hims	elf.	nee propos	ea for the i	nsurea in ti	nis Propo:	sai Form. I	i ne receipt o	i the proce	eas by the	Nomir	nee would be	sufficier	nt discharge	or the Cor	npany. 11	ie i vomine	ee tor
DETAILS OF THE PROP	OSED	ТОВ	E INSU	JRED															
Insured I: Name: Mr./Ms./Mrs.																			
Marital Status		Date	of Birth			1 h	YY	YY	Height	:		cms		Weig	ht:			kg	
Gender Male Female (	Others	Aac	dhaar/PA	N No. (	Optiona	)							Annı	ual Inc	ome (in	Rs.):			
Relationship with Insured :			A	Address															
Occupation type of Domestic Help	:								Nomir	nee (Rel	ationshi	p wit	h Insured	):					
Do you have ABHA No. Yes	No	If \	res, pleas	e provid	e ABHA	Numbe	er (Op	tional)											
Insured 2 : Name : Mr./Ms./Mrs.									76										
Marital Status		Date	of Birth		DN	1 M	ΥY	ΥY	Height	:		cms	5	Weig	ht :			kg	
Gender Male Female	Others	Aac	dhaar/PA	N No. (	Optiona	)							Annı	ual Inc	ome (in	Rs.):	$\Box$		П
Relationship with Insured :			<i>A</i>	Address		/													
Occupation type of Domestic Help	:								Nomir	nee (Rel	ationshi	p wit	h Insured	):					
Do you have ABHA No. Yes	No	If Y	res, pleas	e provid	e ABHA	Numbe	er (Op	tional)						, ·			$\top$		
Insured 3 : Name : Mr./Ms./Mrs.																	+		Н
Marital Status		Date	of Birth			1 M	/ Y	YY	Height			cms		Weig	ht ·			kg	
	Others		dhaar/PA	NI NIo (	Optiona				1 leight						ome (in	Rc V		8	П
Relationship with Insured:	Juleis	Aac				)							Ann	Jai IIIC	one (in	1\5.).			Щ
1			F	Address					NI	(D-I			la la accesa d'	١.					_
Occupation type of Domestic Help  Do you have ABHA No. Yes		lf.	res, pleas	o provid	ο ΛR⊔Λ	Numb	or (Op	tional)	Nomir	nee (Kei	ationsni	p wit	h Insured	):					
,	No		ies, pieas	e provid	e Abria	Nullibe	er (Op	LIOHAI)									+		$\vdash$
Insured 4: Name: Mr./Ms./Mrs.		<b>\</b> -\	<u> </u>			4 5 4 5	/ \ /	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							<u>                                     </u>				Щ
Marital Status			of Birth				ſY	YY	Height	:		cms		Weig	ht :			kg	
Gender Male Female (	Others	Aac	dhaar/PA	N No. (	Optiona	)							Annı	ual Inc	ome (in	Rs.):			Ш
Relationship with Insured :			A	Address															
Occupation type of Domestic Help									Nomir	nee (Rel	ationshi	p wit	h Insured	):					
Do you have ABHA No. Yes	No		res, pleas	e provid	e ABHA	Numbe	er (Op	tional)											
Details										Insu	red I		Insured	2	Insur	ed 3	In	sured 4	4
Have you ever been entrusted with p Government, senior politicians, senio owned corporations or important po	r gover	nment, ju	ıdicial or ı						ate	Y	N		Y	1	Y	N	Y	N	
Does your job require you to be invo				ctivity.si	nificant	manual	labor. o	peratin	g heavy	_		+							
machinery, handling hazardous mater voltage, high temperature, working ir	ial, wor	rking at he	eights / ur	ndergrou	ind / cor	structio	n sites,	oil riggir	ng, high	Υ	N		Y	1	Y	N	Y	N	

MEDICAL / LIFESTYLE RELATED INFORMATION				
Particulars	Insured I	Insured 2	Insured 3	Insured 4
Does 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:				
I. Cancer, tumor, polyp or cyst	YN	Y	Y	Y
	Since	Since	Since	Since
2. Any heart disease or disorder, chest pain or discomfort, irregular heart beats, palpatations or heart	YN	YN	YN	Y
murmur				
	Since	Since	Since	Since
3. Hypertension / High Blood Pressure (BP) / High Cholestrol	YN	Y	Y	Y
3. Type tallian 1. grade (a. ), Tight dilates a.	Since	Since	Since	Since
4. Asthma / Tuberculosis (TB) / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of	YN	YN	YN	YN
Lungs, Pleura and airway or Respiratory disease?	Since	Since	Since	Since
5. Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pitutiary tumor/ disease or	Y	YN	Y	Y
any other disorder of Endocrine system?	Since	Since	Since	Since
	Y N	N	Y N	Y N
6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	Since	Since	Since	Since
7. Motor Neuron Disease/ Muscular dystrophies/ Myasthnia Gravis or any other disease of Neuromuscular	Y	Y	YN	YN
system (muscles and/or nervous system)	Since	Since	Since	Since
8. Stroke/ Paralysis/ Transient Ischemic Attack/ Multiple Sclerosis/ Epilepsy/ Mental-Psychiatric illness/	YN	YN	Y	YN
Parkinsonism/ Alzeihmer's/ Depression / Dementia or any other disease of Brain and Nervous System?	Since	Since	Since	Since
9. Cirrhosis / Hepatitis / Wilson's disease / Pancreatitis / Liver disease / Crohn's disease / Ulcerative Colitis				
/Piles or any other disease of Mouth, Esophagus, Liver, Gall bladder, Stomach or Intestines or any other part	Y	Y N	Y	Y
of Digestive System?	Since	Since	Since	Since
10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of	YN	YN	YN	YN
Kidney, Urinary Tract or reproductive organs?	Since	Since	Since	Since
	311CC	Sirice	511100	3111CC
11. HIV/SLE/ Arthiritis/ Scleroderma / Psoriasis/ bleeding or clotting disorders or any other diseases of Blood,		Y	Y	Y
Bone marrow/ Immunity or Skin.	Since	Since	Since	Since
12. Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by	YN	YN	YN	YN
prescription lenses)?	Since	Since	Since	Since
13. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please indicate the following:	Y N	Y	Y	Y
- Hard Liquor (No.of Pegs in 30 ml per week)	Since	Since	Since	Since
- Beer(Bottles/ml per week)				
- Wine(Glasses/mlper week)				
- Smoking (no. of Sticks per day)				
- Gutka/Pan Masala/Chewing Tobacco(Sachets/Grams per day)				
14. Has any of the Proposed to be insured or his/her family member(1st blood relation) suffering from				
any of the following conditions:	Y N	Y	Y	Y
Down's Syndrome/Turner's Syndrome/Sickle Cell Anaemia/ Thalassemia Major/G6PD deficiency	Since	Since	Since	Since
	YN	YN	YN	YN
15. Any other disease / health adversity / injury/ condition / treatment not mentioned above?	Since	Since	Since	Since
16. Has any of the Proposed to be Insured been hospitalized/recommended to take investigations/medication	YN	Y	Y	YN
or has been under any prolonged treatment/ undergone surgery for any illness/injury other than for				
childbirth/minor injuries?	Since	Since	Since	Since
Note: The Company shall reject Your proposal and refund the premium amount (after deducting cost of medical t		-£:l-t		.  -  -  -    -  -  -  -  -  -  -  -  -
other reason.	ests, ii ariy) iri case	of incompleteness	or any discrepancy	/ nignlignted or any
ADDITIONAL INFORMATION (IF YOUR ANSWER IS 'YES' TO ANY OF THE	ABOVE OU	ESTIONS OR	THE PROPO	SED TO BE
INSURED ARE SUFFERING FROM ANY OTHER PRE EXISITNG DISEASE WH				
				· · · · · · · · · · · · · · · · · · ·
ATTENDING PHYSICIAN'S DETAILS				
Name of Family Physician :				
	Idle Name)		(Last Nam	
	GICT VALITIE)		(Last 1 vdl11	
Contact Number : Email :				

## **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

Details	Insured I	Insured 2	Insured 3	Insured 4
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.	Y	Y	YN	Y
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	Y	Y	YN	YN
Is any of the person(s) proposed for insurance covered under any other health insurance policy with the	Y	Y	YN	Y
Company or any otherCompany without break?	Since	Since	Since	Since
	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(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  $\bar{\text{c}}\text{ompany}.$
- 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.
- lauthorize 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)									
NEFT DETAILS (FOR CLAIMS & REFUND PURPOSES	ES)									
Bank account details of the Proposer (For Refund Purposes)										
Account Number:	IFSC Code:									
Bank Name :	Bank Branch Name :									
Name of the Account Holder:										
Bank account details of the Proposed to be Insured (For Re-imbursement Claims)										
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 (Formerly known as Religare Health Insurance Company 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)									
PREMIUM PAYMENT INFORMATION										

Payment By Cash / Cheque / Demand Draft / Card (Strike out whichever is not applicable):								
Cheque / Demand Draft No. / Authorization ID :								
Payment Amount (₹):	Premium Amount (₹):							
Date:	Bank Name :							
1								

## Key Exclusions:

- Any disease contracted during the first 30 days of the policy start date, except those arising out of accidents. 2 Year Wait Period: Non-infective arthritis/Joint replacement/Cataract/Piles/Fissure/Ear, nose and throat (ENT) disorders and surgeries/Stones, etc.
- Pre-existing Diseases: 48 months from the date of the first policy
- Permanent Exclusions: Non-allopathic treatment / Expenses attributable to self-inflicted injury (resulting from suicide, attempted suicide) or alcohol or drug use, misuse or abuse / Cost of spectacles, contact lenses / dental treatment / Medical expenses incurred for treatment of AIDS / Treatment arising from or traceable to pregnancy and childbirth, miscarriage, abortion and its consequences or relating to infertility and in vitro fertilization / Congenital disease.

Treatment/consultation in a hospital which is named in the negative list of hospitals For a detailed set of exclusions, please log on to www.careinsurance.com.

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.

## **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

DECLARATION FOR AGENTS	
all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Pro any details sought herein will form basis of the Contract of Insurance between the Company and the statement(s)/information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, state	cified Person of the Corporate Agent/ Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained roposer including statement(s)m information and response(s) submitted by him/her in this Proposal Form to questions contained herein Proposer, if this proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue ements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable as per Policy 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
License No. (Advisor/Corporate Agent/Broker/Relationship Officer):	
Date : (DD/MM/YYYY)	Signature :
SP Name :	SP Code:
ADDENDUM - VERNACULAR DECLARATION	
	declare that I have read out and fully explained the contents of the Proposal Form and all other accompanying documents in
$\underline{\hspace{2cm}} language \ to \ the \ Proposer \ which is a language understood by him/her and is imperative him/her and the replies have been recorded according to the information provided by the Proposer. The replies have License No. (Advisor/Corporate Agent/Broker/Relationship Officer):$	e for the Proposer to avail the insurance from the Company . The contents and import of the proposal have been fully understood by a also been read out to, fully understood and confirmed by the Proposer.
Date: / / / (DD/MM/YYYY)	Signature of the declarant :
Place :	(On behalf of all the Proposed to be Insured under the Policy)
Name of the declarant :	
EMPLOYER DECLARATION FORM	
1	
the Domestic Help whose details are set out hereunder,	(Current Residential Address) hereby solemnly declare that I will be availing the services of
Name of the Domestic Help :	
Date of Birth / Incorporation (in case Proposer is an entity) : DDMM	Place of Birth :
Details of Identification proof like Adhar Card /Authorized I Card /Ration Card (if	any):
Current Residential Address :	
Date: / / (DD/MM/YYY) Place:	Signature of the declarant:
Acknowledgement for Proposal	
Please retain this counterfoil for your records  We acknowledge the receipt of payment of ₹	(On behalf of Care Health Insurance Limited) vide Cash/Cheque/DD No./Authorization ID from
Please note that this is only an acknowledgement receipt and does not amount to acceptance	ce of risk or commencement of the Policy. The Company is not liable for any claim between the time that the lization of the proposal amount. Acceptance of proposal and issuance of the Policy shall be subject to receipt of I underwriting decision of the Company.
Proposal No.:	Signature of the Representative :
Name of the Representative:	
Insurance is a subject matter of solicitation. IRDAI Registration No. 148	week Cone Health Incompage Limited houset an array with a first d Dayling Inc.
Note: Should you choose to pay premium by cash, you are advised to do so only at the nea	rest Care Health Insurance Limited branch or any authorized Bank branch, and we insist you to please ask for