Proposal Form- 'Explore Protect Plus'

URN : CHIL / G / TR / 110 / 23-24

Proposal No.:_____

FOR OFFICE USE ONLY

Intermediary Details

Intermediary Code :		Intermediary Name :	
Intermediary RM Code :		Branch Code :	
Customer Acc No. :			

Care Health Insurance Branch Details

CHIL RM Name :			
Branch Code :		Client ID :	Receipt ID :

1. PLEASE NOTE: Please answer all the questions fully and correctly. If any question does not apply, please mention 'Not Applicable' or 'NA'. Please fill 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. The liability of the Company does not commence until this Proposal has been accepted and underwritten by the Company and premium received including loadings, if any. The Policyholder understands and agrees that if the Company accepts a proposal for insurance, it shall be subject to the Policy Terms and Conditions and the Company shall have no liability whatsoever if the premium is not realized, or received in full or in time. In the event the Company does not accept the proposal, Policyholder will be informed of the same and the premium received from Policyholder, if any, will be refunded without interest.
3. If there is insufficient space, please provide further details on a separate sheet.
4. Please contact the Company's Offices for any doubts or clarifications.
5. All attached documents form part of this Proposal.

POLICYHOLDER INFORMATION

Name : (Mr./Ms./Mrs.)			
	(First Name)	(Middle Name)	(Last Name)
Key Person Name : (Mr./Ms./Mrs.)			
	(First Name)	(Middle Name)	(Last Name)
Correspondence Address :			
Locality :		City :	
Pin Code :		State :	
Landmark :			
Permanent Address : If same as above, please tick here ☐			
Locality :		City :	
Pin Code :		State :	
Telephone :		Mobile* :	
Email :			
PAN Number(Mandatory) :		Nationality :	
Form 60 (only in case the customer does not have PAN no.) :	☐ Yes ☐ No	Aadhaar Number(last 4 digits):	X X X X X X X X

Please share the required KYC documents as per Appendix I (mandatory)

(By signing the Proposal form I give my consent for using my Aadhaar No. for Authentication of my Aadhaar Details)

RISK INFORMATION

Add-on Policy Period Start Date : D D M M Y Y Y Y			Add-on Policy Period End Date : D D M M Y Y Y Y	
Cover Type :	☐ Individual			
Trip Type :	☐ Single Trip	☐ Multi-trip		
Purpose of travel :	☐ Business	☐ Seminar	☐ Leisure	☐ Adventure Sports ☐ Educational
	☐ Pilgrimage	☐ Others (if Others, Please provide the description)		

If opted for Multi Trip : Maximum trip duration:	30day	60 days	90 days	180 days
	☐ 7 Days	☐ 7 Days	☐ 7 Days	☐ 7 Days
	☐ 14 Days	☐ 14 Days	☐ 14 Days	☐ 14 Days
			☐ 30 Days	☐ 30 Days
				☐ 60 Days

If opted for Single Trip : _____

Geographical Scope	Number of days required	Maximum Trip Duration Required	Age Band
Worldwide excluding India	☐ _____	_____	_____
Worldwide excluding US/ Canada/India	☐ _____	_____	_____
Europe	☐ _____	_____	_____
Asia excluding India	☐ _____	_____	_____
India	☐ _____	_____	_____

Details of Benefit(s) as per Final quote (Annexure – I)

DETAILS OF PERSONS TO BE INSURED (DETAILS REQUIRE AT THE TIME OF CERTIFICATE OF INSURANCE ISSUANCE)

Please provide complete details of Proposed to be insured in the format decided by the Master Policyholder & the Insurer.

PREMIUM PAYMENT INFORMATION

Mode of payment : Cash/Cheque / Demand Draft / NEFT / Any other mode (Strike out whichever is not applicable)			
Cheque / Demand Draft No. / Authorization ID :			
Payment Amount (₹) :		Premium Amount (₹) :	
Date :		Bank Name :	
Sources of Funds :	☐ Salary ☐ Business ☐ Others	(if others, please specify) :	

In case of payment through Cheque / Demand Draft, it should be drawn in favor 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.

MATERIAL DISCLOSURES

Any additional information relevant to the policy applied for

_____

_____

_____

Note: Please use additional sheets if space is not sufficient to give details

PROPOSER'S DECLARATION

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

F. I hereby consent to receiving information from Central CKYC Registry through SMS/Email on the above registered email address/number.

Place: _____

Date: _____(DD/MM/YYYY)

Signature of the Proposer

(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 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.
2. 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.

Annexure – I (Coverage Opted for Benefits)

Select Option	Optional Benefits	Payout Basis	Coverage Amount	Deductible
☐	Base Benefit 1 : Trip Cancellation & Interruption	Indemnity	Min: US $ 50/ € 35/ INR 1,000 Max: US $ 7,500/ € 5,500/ INR 100,000 Coverage Opted : _____	up to $500/ up to €375/ Up to INR 30,000 Deductible Opted : _____
☐	Base Benefit 2: Refund of Visa Fee	Indemnity	Min: US $ 100/ € 100 Max: US $ 500/ € 500 Coverage Opted : _____	N.A.
☐	Base Benefit 3: Loss of checked-in Baggage	Benefit	Min: US $ 50/ € 50/ INR 1,000 Max: US $ 500/ € 500/ INR 30,000 Coverage Opted : _____	N.A.
☐	Base Benefit 4: Multi trip options	N.A.	Multi Trip options (per year): ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days Max. days per Trip options: 7, 14 / 7, 14, 30 / 7, 14, 30 / 7, 14, 30, 60	N.A.
☐	Base Benefit 5: Burglary (Home Contents)	Indemnity	Upto INR 10K / 25K/ 50K/ 1 lac/2 lac Coverage Opted : _____	No Deductible ☐ INR 5000 ☐
☐	Base Benefit 6: Home to Home cover	N.A.	Up to Base Policy Coverage amount Note: Available under following: • Medical Cover and/or its Optional Extension: Pre Existing Disease Cover In Life Threatening Medical Condition and/or • Personal Accident and/or • Out-patient Cover and/or its Optional Extension Pre-Existing Disease Cover In Life Threatening Medical Condition	N.A.

Note: The above list may vary depending upon the Benefits opted by the Insured Person/ Group Administrator (Policyholder)

APPENDIX 1:

For Companies - Name of the company - Principal place of business - Mailing address of the company - Telephone/Fax Number	(i) Certificate of incorporation and Memorandum & Articles of Association (ii) Resolution of the Board of Directors to open an account and identification of those who have authority to operate the account (iii) Power of Attorney granted to its managers, officers or employees to transact business on its behalf (iv) Copy of the telephone bill (v) Copy of PAN allotment letter
For Partnership firms - Legal name - Address - Names of all partners and their addresses - Telephone numbers of the firm and partners	(i) Registration certificate, if registered (ii) Partnership deed (iii) Power of Attorney granted to a partner or an employee of the firm to transact business on its behalf (iv) Any officially valid document identifying the partners and the persons holding the Power of Attorney and their addresses (v) Telephone bill in the name of firm/partners
For Trusts & Foundations - Names of trustees, settlers, beneficiaries and signatories - Names and addresses of the founder, the managers/directors and the beneficiaries - Telephone/fax numbers	(i) Certificate of registration, if registered (ii) Power of Attorney granted to transact business on its behalf (iii) Any officially valid document to identify the trustees, settlors, beneficiaries and those holding Power of Attorney, founders/managers/ directors and their addresses (iv) Resolution of the managing body of the foundation/association (v) Telephone bill

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 Declaran : _____

(On behalf of all the Proposed to be Insured under the Policy)

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 Rs. _____ vide Cash / Cheque / DD / Authorization ID. _____ from _____

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. IRDA 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.