care HEALTH INSURANCE

Proposal Form - 'GRAMEEN CARE PLUS' - Micro Insurance Product

Unique Reference Number: CHIL / G / MI / 097 / 22-23
Proposal No.:______________________

For Office Use Only

Intermediary Details

Intermediary Name :

Intermediary Code : Intermediary RM Code :

Branch Code : Customer Acc No.:

Care Health Insurance Branch Details

CHIL RM Name :

Branch Code : Client ID : Receipt ID :

PLEASE NOTE :

1. To be filled in by the Proposer 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. In the event the Company does not accept the proposal, You will be informed of the same and the premium received from You, if any, will be refunded without interest.
3. 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 "Proposer", "You" or "Your".

Proposer Details

Name :
(First Name) (Last Name)

Date of Incorporation / Date of Birth : / / (DD/MM/YYYY)

Communication Address :

Locality : City :

State : Pin Code :

Landmark :

Landline : - Mobile :

E-mail ID :

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

Identification No. / Bank Account No. / Aadhaar Card No./any other :

Policy Details

Policy Period : Start Date : / / (DD/MM/YYYY)

Midnight of End Date : / / (DD/MM/YYYY)

Policy opted on : ☐ Individual basis ☐ Floater basis

If opted on floater basis then Family Combination Opted : ☐ 1 Member ☐ 2 Members ☐ 3 Members ☐ 4 Members ☐ 5 Members ☐ 6 Members

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

Details of the Proposed to be Insured

Please provide complete details of Proposed to be Insured as per Annexure- I attached

Note : The Company shall reject Your proposal and refund the premium amount in case of incompleteness or any discrepancy highlighted or any other reason.

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Material Disclosures

Any additional information relevant to the policy applied for

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

Past Policy and Claim Details

1. Kindly provide particulars for the past 3 (three) policy periods for which policy was availed.

Policy Period (From - To) (DD/MM/YYYY)	Name & Address of the Insurer	Policy No.	Total Premium	Total No. of claims (Paid + Outstanding)	Total Amount of claims (Paid+ Outstanding)	Total No. of Lives Insured (including endorsements at end of policy)	Name of TPA, if any
			₹	₹	₹		
			₹	₹	₹		
			₹	₹	₹		

2. Please provide details on the following condition(s)

Condition(s) applicable to your health insurance policy	Yes/No	Name of Insurance Company	Address
1. Declined to continue			
2. Not invited renewal			
3. Imposed any restrictions or special conditions			

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 insurance company 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 assured / proposer and seeking information from any insurance company 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.

Date : __ __ / __ __ / __ __ __ __

Place :

Signature of the Proposer : ______________________

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

Premium Payment Information

Premium Amount (₹) :

Payment by : Cheque / Demand Draft / Card //ECS (NACH)/Reward Points/Wallet/ Any Other Mode (Strike out whichever is not applicable)

Cheque / Demand Draft No. / Authorization ID :

Date : __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) Payment Amount (₹) :

Bank Name :

In case of payment through Cheque/Demand Draft, the instrument should be drawn in favour of **"Care Health Insurance Limited."**

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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.

Addendum - Vernacular Declaration

I ____________________, son/daughter of ___________________, resident of _________________________ declare that Ihave 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 : ☐☐ / ☐☐ / ☐☐☐☐

Name of the Declarant : ______________________________________

Place : ____

Signature of the Declarant : ____________________________________

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

Grameen Care Plus - Annexure – I to Proposal Form- Enrollment Data (Illustrative)

Policyholder Name	Policyholder Identification No/ Bank Account No / Aadhaar No	Primary Insured Member ID	Insured Member/ Dependent Name	Sum Insured	Address of Primary Insured Member	DOJ (DD/MM/YY)	Age/ Date of Birth	Relationship with Primary Insured Member	Gender	Nominee	Do you have ABHA No. ? If Yes, please mention

Appendix I

For Companies	
Name of the company	(I) Certificate of incorporation and Memorandum & Articles of Association
Principal place of business	(II) Resolution of the Board of Directors to open an account and identification of those who have authority to operate the account
Mailing address of the company	(III) Power of Attorney granted to its managers, officers or employees to transact business on its behalf
Telephone/Fax Number	(IV) Copy of the telephone bill
	(V) Copy of PAN allotment letter

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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

Grameen Care Plus - Annexure – I (Coverage Opted for – Base Benefits/Optional Benefits)

S. No.	Name of Base Benefits /Optional Benefit	Coverage opted (Yes/No)	Sum Insured (Rs)
1	Base Benefit 1:Hospitalization Expenses	Y N	
2	Base Benefit 2: Accidental Death	Y N	
3	Base Benefit 3: Permanent Total Disablement	Y N	
4	Base Benefit 4: Permanent Partial Disablement	Y N	
5	Optional Benefit 1: Accidental hospitalization	Y N	
6	Optional Benefit 2 : Waiver of Initial Waiting period	Y N	NA
7	Optional Benefit 3: Waiver of Maternity Waiting period	Y N	NA
8	Optional Benefit 4: Modification of Pre & Post Hospitalization Medical Expenses	Y N If Yes, Select the Max. no. of payable Duration: Pre/Post hospitalization (No. of days) – Tick mark the selected option 30/60 ☐ 60/90 ☐	NA
9	Optional Benefit 5: Modification of Maternity Expenses	Y N	NA
10	Optional Benefit 6: Daily Cash Allowance	Y N	
11	Optional Benefit 7: Room Rent Modification	Y N S. No. | Non-ICU Room category per day | ICU Room category per day | Tick mark the selected option 1 | 2% | 4% | ☐ 2 | No limit | No limit | ☐	NA

Note: The above list may vary depending upon the Base Benefit/Optional Benefit opted by the Group Administrator (Policyholder).

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 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 : ______________________________

NOT VALID AGAINST CASH

Insurance is a subject matter of solicitation. IRDAI Registration No. 148

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