

Proposal Form - 'Group Arogya Sanjeevani Policy-Care Health Insurance'

URN: CHIL / G / HE / 091 / 22-23

Proposal No.: _____

For Office Use Only
Intermediary Details

Intermediary Name :	<input type="text"/>														
Intermediary Code :	<input type="text"/>					Intermediary RM Code :	<input type="text"/>								
Intermediary Branch Code :	<input type="text"/>					Business Sector :	<input type="text"/>								

Care Health Insurance Branch Details

Sales Manager Name :	<input type="text"/>																								
Branch Code :	<input type="text"/>					Client ID :	<input type="text"/>					Receipt ID :	<input type="text"/>												

- 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.
- The proposed policyholder will be referred to in this Proposal Form as "Proposer", "You" or "Your".

Proposer Details

Full name of the Proposer/Entity :	<input type="text"/>																										
Date of Incorporation/Date of Birth :	<input type="text"/>		/	<input type="text"/>		/	<input type="text"/>		(DD/MM/YYYY)																		
Correspondence Address :	<input type="text"/>																										
Locality :	<input type="text"/>										City :	<input type="text"/>															
Pin Code :	<input type="text"/>					State :	<input type="text"/>																				
Landmark :	<input type="text"/>																										
Permanent Address : <small>(if same as above please tick here)</small>	<input type="text"/>																										
Locality :	<input type="text"/>										City :	<input type="text"/>															
Pin Code :	<input type="text"/>					State :	<input type="text"/>																				
Landmark :	<input type="text"/>																										
Contact Details:	Land line (R) :	<input type="text"/>										(O) :	<input type="text"/>														
		(STD Code)											(STD Code)														
	Mobile No :	<input type="text"/>																									
	E-mail ID :	<input type="text"/>																									

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

 P.A.N. (Mandatory) : Please share the required KYC documents as per Appendix I (mandatory)

 Do all the members proposed to be insured form part of one Group or Association or Corporate body? Yes No

 Is the scheme contributory Yes No

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

Date : / /

Signature of the Authorized Signatory : _____

Place :

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

Premium Payment Information

Premium Amount :

Payment By : Cheque / Demand Draft No. / Any other Mode (Strike out whichever is not applicable)

Cheque / Demand Draft No. / Authorization ID :

Date : / /

Payment Amount (INR) :

Bank Name :

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

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.

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 : / /

Name of the Declarant : _____

Place : _____

Signature of the Declarant : _____

(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)

We acknowledge the receipt of payment of ₹ _____ vide Cheque/DD No. _____ from M/S. _____ Please note that this is only an acknowledgement receipt and does not amount to acceptance of risk or commencement of policy. Care Health Insurance Limited is not liable for any claim between the time that the proposal amount is received and policy start date. The validity of receipt is subject to realization of proposal amount. Acceptance of proposal & issuance of Policy shall be subject to receipt of completed proposal form, premium payment, medical reports (wherever applicable) and underwriting decision of the Company.

NOT VALID AGAINST CASH

Proposal No.: _____

Signature of the Representative : _____

Name of the Representative : _____

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

Care Health Insurance Limited

Regd. 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: CHIHLGP21597V012021 IRDAI Registration No. - 148

Group Arogya Sanjeevani Policy-Care Health Insurance - Annexure - I to Proposal Form - Enrollment Data (Illustrative)

Policyholder Name	Policyholder Identification No/Bank Account No.	Primary Insured Member ID	Insured Member/ Dependent Name	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

Section A : Medical Declaration

Part A

Please consider the following questions as they apply to each of the Member	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Have you or any of the persons proposed for insurance suffered from any of the following disease and/or have undergone treatment in a hospital for these disease/for any	<input type="checkbox"/> Y <input type="checkbox"/> N				
Details	Existing Since _____				
1. Cancer /tumor	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
2. Brain / Nervous System Disorders (For example: Stroke, Paralysis, Dementia, Epilepsy, Multiple Sclerosis, Psychiatric)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
3. Heart disease (For example: Coronary Artery Disease, Hypertension, Valve disease, Chest Pain, Heart Failure or	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
4. Chronic Lung Disease (For example: Asthma, COPD, Tuberculosis, Bronchitis, Emphysema, Pleural Effusion)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
5. Chronic Liver/Gastrointestinal Disease (For Example: Cirrhosis, Hepatitis, Pancreatitis, other Liver disease, Crohn's disease, Ulcerative Colitis, Piles)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
6. Diabetes with complications / or on Insulin (For example: Kidney Disease, Eye Disease, Foot Ulcer, Neuropathy)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
7. Chronic Kidney Disease (For example: Kidney Stones/ Renal Failure/ Dialysis/CKD/Nephritis)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
8. Blood Disorders/ Auto-Immune Diseases Thalassemia Major (For example: Anemia, Bleeding Disorders, Immune - Endocrine/ Muscular/Neuro-Muscular/Bone Diseases (For Example: Thyroid, Pituitary, Muscular Dystrophies, Arthritis, Myasthenia Gravis)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
9. Disease of Reproductive and Urinary system (For example: Fibroids, Breast lumps, Hernia, Hydrocele, Menorrhagia, Prostate disorders)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
10. Others (please Specify)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
11. Has anyone been diagnosed / hospitalized or under any treatment for any illness/injury in the past?	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				
12. Is anyone of the Insured's family member (1st blood relationship) is suffering from any genetic disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____				

Note: The Company shall reject Your proposal and refund the premium amount (after deducting cost of medical tests, if any) in case of incompleteness or any discrepancy highlighted or any other reason.

Part B

This part applies if indicated 'Yes' in Part A replies. Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply.

Name of patient	Relevant section of Part A	Nature of illness/disability and treatment received	When did it start	How long did it last	Need for any further treatment or consultation	Present state of health in this respect

Signature of the Primary Insured Member : _____

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

Section B : (Corporate Declaration)

Questions to be completed by the Applicant's Authorized Personnel for all the persons (employees and dependents, if applicable) to be insured:

Note: If any of the answer is 'Yes', each concerned person(s) will have to go through a personal health declaration and any declared medical conditions will be subject to an underwriting decision.

1. Based on your company employee leave records, in the past two (2) years, has any person to be insured been:
 - On sick leave or hospital leave for five (5) consecutive days or more; or
 - On hospital leave for 2 times or more
2. Is any person to be insured currently hospitalized or been told that any medical treatment that is likely to result in an inpatient stay in the hospital or surgery, is required?
3. During the past two (2) years, has any person to be insured been diagnosed with, or under treatment, or investigation or follow up for any of the following condition:
 - a) Cardiovascular Diseases: Include coronary artery disease, myocardial infarction, aortic aneurysm, heart failure, cardiac arrhythmia, heart valvular disease, ischemic heart disease.
 - b) Neurological Conditions: Include stroke, brain aneurysm, Alzheimer's disease, Parkinson's disease, Syringomyelia, Multiple sclerosis, schizophrenia, epilepsy, Motor neuron disease;
 - c) Hematologic disease: Include leukemia, lymphoma, aplastic anemia, Thrombocytopenic purpura, hemophilia
 - d) Respiratory System: Include chronic obstructive pulmonary disease, primary pulmonary hypertension; pulmonary tuberculosis
 - e) Digestive System: Include liver or hepatic cirrhosis, severe hepatitis such as but not limited to Hepatitis B, Hepatitis C.
 - f) Urinary System: Include nephrotic syndrome, renal failure, renal dialysis
 - g) Autoimmune Disease include: systemic lupus erythematosus, systemic scleroderma, AIDS
 - h) Others: Include all malignant tumor; brain tumour; major organ failure/transplant, diabetes and complication, mental illness and drug alcohol problem.
4. During the last 6 months has any person to be insured or been advised by a doctor or a health professional or an alternative practitioner to take, or taking, any repeat medication or injections, whether prescribed or not, for at least 3 times a week and for a minimum period of 3 weeks or had in aggregate 4 or more visits to a doctor or a health professional?

(This would exclude visits for 'malaria, dengue fever, typhoid, accidental injuries' where the person to be insured has been fully discharged by the doctor and he/she does not require any follow up consultation or further diagnostic/laboratory tests. For female to be insured- this would exclude normal childbirth where there is/had not been any complication in pregnancy and childbirth. This would exclude vitamins, food and health supplements and anti-oxidants)

Signature of the Authorized Personnel : _____

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

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
For Partnership firms	
Legal name	(I) Registration certificate, if registered
Address	(II) Partnership deed
Names of all partners and their addresses	(III) Power of Attorney granted to a partner or an employee of the firm to transact business on its behalf
Telephone numbers of the firm and partners	(iv) Any officially valid document identifying the partners and the person 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	(I) Certificate of registration, if registered
Names and addresses of the founder, the managers/directors and the beneficiaries	(II) Power of Attorney granted to transact business on its behalf (III) Any officially valid document to identify the trustees, settlers, beneficiaries and those holding Power of Attorney, founders/managers/ directors and their addresses
Telephone/fax numbers	(iv) Resolution of the managing body of the foundation/association (v) Telephone bill