care HEALTH INSURANCE

Proposal Form - 'Group Care'

URN: CHIL / G / PK / 101 / 22-23

Proposal No.:_____

For Office Use Only

Intermediary Details

Intermediary Name :

Intermediary Code : Intermediary RM Code :

Intermediary Branch Code : Business Sector :

Care Health Branch Details

Sales Manager Name :

Branch Code : Client ID : Receipt ID :

1. 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 Company retains the right in its sole and absolute discretion to issue a 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. You understand and agree 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, 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, 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.

SCOPE OF COVER

We will indemnify the Medical Expenses incurred on Hospitalization expenses incurred for diseases contracted or injuries sustained in India. to Room Rent Limit and ICU charges as per Quote

SIGNIFICANT EXCLUSIONS

The following is an indicative list of exclusions from the cover under the Policy. For a detailed set of exclusions, kindly refer the Policy.

Pre Existing Conditions, any Medical Expenses incurred for treatment of any Illness during the first 30 days of the Cover Start Date, certain specified diseases during first 24 months of the Cover Start Date and Permanent Exclusions like Cost of Spectacles/ Contact Lenses, Dental/Oral Treatment, HIV and AIDS and Pregnancy.

OPTIONAL EXTENSIONS

In addition, certain Optional Extension are available on payment of additional premium, the details of which, are provided in the relevant section of this proposal form.

NOTE : The foregoing is only an indication of the cover offered. For details, please refer to the Policy.

Proposer Details

Full name of the Proposer/Entity :

Key contact person name :

Contact details of Key Contact person :

Address for Communication :

City :

State : Pin Code :

E-mail :

Nature of Business/Business Description :

PAN (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

Details of the persons to be Insured

No. of persons to be Insured :

Please provide complete details in the attached "Annexure A" for persons to be Insured.

Policy and Claims Services

In House/TPA (strike out whichever is not applicable)

Name (If TPA is selected) : _____

Past Policy and Claim Details

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 + O/s)	Total Amount of claims (Paid + O/s)	Total No. of Lives Insured (including endorsements)	Name of TPA, if any
			₹	₹	₹		
			₹	₹	₹		
			₹	₹	₹		

Please provide details on the following condition(s)?

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

Material Disclosures

Any additional information relevant to the policy applied for : _____

_____

Optional Extension opted for

If you want to avail Optional Extensions of the policy, please specify below. Please note that an Optional Extension of the policy may be subject to payment of additional premium or a discount in premium depending on the type of Optional Extension opted:

S.No.	Description	Sub Limit Opted (fixed ₹ or as a % of SI)	Wait Period in months (if any)	Opted (Yes/No)
1	^Pre-Hospitalization Medical Expenses & Post-Hospitalization Medical Expenses			
2	^Pre-Hospitalization Medical Expenses & Post-Hospitalization Medical Expenses Benefit			
3	Domestic Road Ambulance			
4	*Maternity Expenses-Delivery Only			
5	*Maternity Expenses Comprehensive Cover			
	(a) Maternity - Delivery			
	(b) Pre Natal and Post Natal			
	(c) New Born baby			
6	Donor Expenses			
7	Second Opinion			
8	OPD Treatment			
9	Domiciliary Hospitalization			
10	Dental Treatment			
11	Alternative Treatments (IPD basis)			
12	Major Diagnostics			
13	Comprehensive STD Cover			
14	Patient Care			
15	Durable Medical Equipment			
16	*Maternity Complications			
17	Domiciliary Treatment			
18	Cover extended outside India			

19	Corporate Floater			
20	Health Check-up			
21	Alternate Treatments (OPD basis)			
22	Additional Services			
	(a) Health Card in physical form			
	(b) Doctor On Call			
	(c) Health risk assessment			
23	Floater			
24	Sub-Floater			
25	Modification of Waiting Period			
26	Premium Installment Facility			
27	Deductible			
28	Network limited to specified geographies			
29	Network limited to Preferred Providers			
30	Sub-limits on Medical Expenses			
31	Hospital Accommodation - Twin Sharing			
32	Hospital Accommodation - Single Private Room			
33	Sub-limits on Illness/Surgeries/Procedures			
34	Co-payment			
35	STD Cover			

^Note: Optional Extensions # 1 and 2 are mutually exclusive.
*Note: Optional Extensions # 4, #5 and #16 are mutually exclusive

Signature of the Authorised Signatory : _____ Name and Designation : _____

Declaration

a. 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 receipt of the premium chargeable.

b. I/We further declare that I/We 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.

c. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be

insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

d. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority.

e. I/We have read and understood the brochure, prospectus, sales literature, terms and conditions of the Policy, Optional Extensions and confirm to abide by the same.

f. Receipt of proposal form by the Company shall not be construed as acceptance of proposal. Commencement of risk under the Policy shall be subject to realization of full premium and acceptance by the Company. The Company at its sole discretion reserves the right to accept or reject or load any proposal. Policy would start from the date as specified in the Policy Certificate.

g. I understand that the Policy Period Start Date as specified in the Policy Certificate shall be from the 00:00 hrs of the next day of the Proposal receipt at branch, proposed policy period start date as opted by me or cheque date, whichever is later.

h. I/we hereby declare that the lives proposed to be insured would submit to medical examinations before the nominated doctors of the Company, or undergo diagnostic or other medical tests, as suggested by the company for its underwriting wherever applicable.

i. I/we authorize the Company to use and disclose any personal information collected or available with the Company in relation to the persons to be insured (whether obtained with this Proposal or otherwise) to other underwriting companies, claim investigation companies/agencies, service provider, assistance company/any statutory body and insurance/re-insurance companies for the purpose of processing of this proposal and providing subsequent services.

j. I/we consent to provide valid age/employment/membership proof/any other document as sought by the Company in respect to insured persons at the time of claim or at other time as sought for.

k. I/we understand that the Policy shall become void at the option of the Company, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure of any material fact in the Proposal form/personal statement, declaration and connected documents, or any material information having been withheld by me/us or anyone acting on my/our behalf.

l. I/We consent to receive information from the Company through physical documents or electronic or telecommunication means from time to time.

m. Bonafide Source of funds for payment

(i) I/we hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act, 2002 and applicable laws.

(ii) I understand that the Company has the right to call for documents to establish sources of funds.

(iii) The insurance company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

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

I/we, the undersigned hereby declare on my/our behalf and on behalf of each of the persons proposed to be insured that the above statements and particulars are true, accurate and complete and correct in all respects and that there is all information which is relevant to this proposal that has been disclosed and not withheld from the Company. I/we declare that the money used to make the premium payment has not been derived from any illegal activity or unaccounted funds. I further declare and agree that this declaration and the answers given above shall be held to be promissory and shall be the basis of the contract between me/us and the Company. I/We 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/We am/are authorized to propose on behalf of these other persons.

Date : / / Signature of the Authorized Signatory : _____

Place : Name & Designation : _____

(Annexure A attached)

Proposed Coverage and Payment Details

Proposed Policy Period : From (00:00 hours) / / (DD/MM/YYYY) To (midnight) / /

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

Premium payment Frequency : Single Half Yearly Quarterly Monthly

Instrument No.: Instrument Date : / / (DD/MM/YYYY)

Bank Name :

Premium Amount (₹) :

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

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

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.

Appendix I

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

Annexure - A 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