

Proposal Form - 'Group Credit Protection'

URN: CHIL / G / PK / 078 / 22-23

Proposal No.: _____

For Office Use Only

Intermediary Details

Intermediary Name :

Intermediary Code : Intermediary RM Code :

Intermediary Branch Code : Business Sector :

Care Health Insurance Branch Details

Sales Manager Name :

Branch Code : Client ID : Receipt ID :

- 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 policy holder will be referred to in this Proposal Form as "Proposer", "You" or "Your".

Proposer Details

Full name of the Proposer/Entity :

Key contact person name :

Contact details of Key Contact person :

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

Communication :

Address :

Locality : City :

Pin Code : State :

Landmark :

Contact Details: Land line (R) : (STD Code) (O) : (STD Code)

Mobile No :

E-mail ID :

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

Details of the Proposed to be Insured

Please provide complete details of Proposed to be Insured as per Annexure.

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

Policy Details

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

Coverage Type : Individual Family

If Family coverage type is opted, then the Member Combination chosen: Members

If Family coverage type is opted, then Coverage for Optional Benefit 3 & its Optional covers is on Individual basis Floater basis

Details of Optional Benefit(s) and Optional Cover(s) as per Final quote and/or Annexure - I

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			

Material Disclosures

Any additional information relevant to the policy applied for : _____

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

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."**

Key Exclusions:

- Any disease contracted during the first 30 days of the Cover start date, except those arising out of accidents.
- Claims with respect to diagnosis / treatment of any Pre-existing Disease will not be admissible during the first 48 consecutive months of coverage.
- 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 / Medical expenses incurred for treatment of AIDS.

For a detailed set of exclusions, please log on to www.careinsurance.com.

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.

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: RHIHLGP21405V032021 IRDAI Registration No. - 148

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 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	(I) Certificate of registration, if registered (II) Power of Attorney granted to transact business on its behalf
Names and addresses of the founder; the managers/directors and the beneficiaries	(III) Any officially valid document to identify the trustees, settlors, 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

Annexure – I (Coverage Opted for - Optional Benefit / Optional Cover)

Coverage opted (✓)	S. No.	Name of Optional Benefit or Optional Cover	Special Terms & Conditions	Coverage Amount	Deductible	Co-payment
	1	Optional Benefit 1: Smart Criti-care				
	1.1	Optional Cover 1 : Modification of Survival Period				
	1.2	Optional Cover 2 : HIV Cover				
	2	Optional Benefit 2: Smart Acci-Care				
		(i) Accidental Death				
		(ii) Permanent Total Disablement				
		(iii) Permanent Partial Disablement				
	2.1	Optional Cover 1 : Fractures				
	2.2	Optional Cover 2 : Disappearance				
	2.3	Optional Cover 3 : Burns				
	2.4	Optional Cover 4 : Repatriation of Mortal Remains				
	2.5	Optional Cover 5 : Accidental Hospitalization				
	2.6	Optional Cover 6 : Temporary Total Disablement				
	2.7	Optional Cover 7 : Suicide Cover				
	2.8	Optional Cover 8 : Modification of Home / Vehicle				

	3	Optional Benefit 3: Smart Hospi-Care Plus			
	3.1	Optional Cover 1 : Pre & Post Hospitalization Medical Expenses Modification			
	3.2	Optional Cover 2 : Room Rent Modification			
	3.3	Optional Cover 3 : Maternity Expenses			
	3.4	Optional Cover 4 : Organ Donor Expenses			
	3.5	Optional Cover 5 : International Second Opinion			
	3.6	Optional Cover 6 : Modification of 'Initial Wait Period			
	3.7	Optional Cover 7 : 'Pre-Existing Diseases' Modification			
	3.8	Optional Cover 8 : 'Named Ailments' Modification			
	3.9	Optional Cover 9 : Smart Flexi Care			
	3.10	Optional Cover 10 : Sub-limits on Hospitalization Expenses			
	3.11	Optional Cover 11 : Co-Payment Option			
	3.12	Optional Cover 12 : Smart Select			
	3.13	Optional Cover 13 : OPD Care			
	3.14	Optional Cover 14 : Everyday Care			
	3.15	Optional Cover 15 : No Claims Bonus			
	3.16	Optional Cover 16 : Annual Health Check-up			
	4	Optional Benefit 4: Smart Hospi Cash			
	4.1	Optional Cover 1: 'Deductible' Modification			
	4.2	Optional Cover 2 : 'Pre-Existing Diseases' Modification			
	4.3	Optional Cover 3 : 'Named Ailments' Modification			
	4.4	Optional Cover 4 : Maternity Benefit			
	4.5	Optional Cover 5 : ICU Cash Benefit			
		Optional Covers available for Multiple Optional Benefits	Attachment with only One Optional Benefit as under		
	a)	Optional Cover A: Flexible Recovery Benefit	i) Smart Criti-Care (Optional Benefit 1) ii) Smart Acci-Care (Optional Benefit 2) iii) Smart Hospi Care Plus (Optional Benefit 3) iv) Smart Hospi Cash (Optional Benefit 4)		
	b)	Optional Cover B: Child Education	i) Smart Criti-Care (Optional Benefit 1) ii) Smart Acci-Care (Optional Benefit 2)		
	c)	Optional Cover C: Loss of Employment	i) Smart Criti-Care (Optional Benefit 1) ii) Smart Acci-Care (Optional Benefit 2)		
	d)	Optional Cover D: Accidental Hospitalization Cash	i) Smart Acci-Care (Optional Benefit 2) ii) Smart Hospi Cash (Optional Benefit 4)		

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