care HEALTH INSURANCE

Proposal Form - 'GROUP EXPLORE'

T

URN.: CHIL / G / TR / 105 / 22-23
Proposal No.: _____

For Office Use Only

Intermediary Details

Intermediary Name :

Intermediary Code : Intermediary RM Code :

Intermediary Branch Code : Customer Acc No.:

Care Health 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

☐ Mr. ☐ Ms. ☐ M/s

Full Name of the Proposer (Entity) :

(First Name) (Middle Name) (Last Name)

☐ Mr. ☐ Ms.

Key Contact Person Name :

(First Name) (Last Name)

Key Contact Person Details :

Address :

City :

State : Pin Code :

E-mail :

Nature of Business/Business Description :

PAN No. (Mandatory) :

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

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: IRDAI/HLT/RHI/P-T/V.1/53/2014-15 IRDAI Registration No. - 148

Risk Information

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

End Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Group Cover Type : ☐ Individual ☐ Floater

Trip Type : ☐ Single Trip

If opted for Annual Multi Trip :

Maximum trip duration : ☐ 30days ☐ 45 days ☐ 60 days ☐ 90 days

Purpose of visit : ☐ Business ☐ Seminar ☐ Leisure ☐ Adventure Sports

☐ Educational ☐ Pilgrimage ☐ Others, please specify |_____|

If opted for Single Trip :

Geographical Scope		No. 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, Optional Benefit(s) and Optional Extension(s) as per Final quote and/or Annexure – I

Expiring Policy Details

Number of lives covered : _____ Number of man-days : _____ Maximum trip duration : _____

Total premium paid (excluding service tax) : _____

Claim incurred : _____ (Claims Paid plus Claims outstanding)

Claim is available up to which date : _____

Claim detail :

Nature of claim	Geographical Scope									
	Worldwide excluding India		Worldwide excluding US, Canada & India		Europe		Asia excluding India		India	
	No. of claim	Amount	No. of claim	Amount	No. of claim	Amount	No. of claim	Amount	No. of claim	Amount
Medical										
Non-medical										

Details of the 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.

Payment Information

Mode of payment : Cheque / Demand Draft / NEFT / Any other mode (Strike out whichever is not applicable)

Instrument no : ☐☐☐☐☐☐

Instrument Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Payment Amount (₹) : ☐☐☐☐☐☐

Bank Name : ☐☐

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

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 / 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.

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 receipt of the premium chargeable.

c. 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.

d. 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.

e. 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.

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)

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 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 : ☐☐ / ☐☐ / ☐☐☐☐

Place : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name of the Declarant : _____

Signature of the Declarant : _____

(On behalf of all the persons 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 ₹_____ 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 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.

Signature of the Representative : _____ Name of the Representative : _____

NOT VALID AGAINST CASH

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

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 – I (Coverage Opted for – Benefit / Optional Benefit / Optional Extension)

Coverage opted	S. No.	Name of Benefit or Optional Benefit or Optional Extension	Special Terms & Conditions	Sum Insured	Deductible	Co-payment
	1.	Benefit – Medical Cover				
		a.1 In-Patient Care; Or; a.2 In-patient Care For Injury				
		b. Day care Treatment				
		Note - 'In-patient Care with Day care Treatment' includes 'Pre-Existing Disease Cover In Life Threatening Medical Condition' for up to 10% of Sum Insured of Medical Cover				
		c. Optional Extensions to Benefit – 'Medical Cover':-				
		i. Optional Extension 1 : Pre-Existing Disease Cover In Life Threatening Medical Condition				
		ii. Optional Extension 2 : Extended Cover in the Country of Residence / City of Residence				
		iii. Optional Extension 3 : Automatic Extension				
		iv. Optional Extension 4 : Additional Sum Insured In Case Of Accident				
		v. Optional Extension 5 : Maternity				
		vi. Optional Extension 6 : Treatment of Mental & Nervous Disorder				
		vii. Optional Extension 7 : HIV / AIDS Cover				
		viii. Optional Extension 8 : Drug And Alcohol Abuse				
		ix. Optional Extension 9 : Self-Inflicted Injury				
		x. Optional Extension 10 : Maternity Complications				
		xi. Optional Extension 11 : Sub-Limit On Medical Expenses				
		xii. Optional Extension 12 : Adventure Sports Injury				
		xiii. Optional Extension 13 : Corporate Floater				
		xiv. Optional Extension 14 : Recharge of Sum Insured				
	2.	Optional Benefit – Medical Evacuation				
	3.	Optional Benefit – Repatriation of Mortal Remains				
	4.	Optional Benefit – Dental Expenses				
	5.	Optional Benefit – Loss of Passport				
	6.	Optional Benefit – Loss of Checked-in Baggage				

	7.	Optional Benefit – Delay of Checked-in Baggage				
	8.	Optional Benefit – Personal Accident				
	9.	Optional Benefit – Common Carrier Fatality				
		a.1 Common Carrier Fatality - all Common Carrier; Or; a.2 Common Carrier Fatality – Flight only				
	10.	Optional Benefit – Personal Liability				
	11.	Optional Benefit – Hijack Distress Allowance				
	12.	Optional Benefit – Emergency Cash Advance				
	13.	Optional Benefit – Trip Cancellation & Interruption				
	14.	Optional Benefit – Trip Delay				
	15.	Optional Benefit – Missed Connection				
	16.	Optional Benefit – Spectacles Damage				
	17.	Optional Benefit – Identity Document Theft				
	18.	Optional Benefit – Bounced Booking				
	19.	Optional Benefit – Political Risk and Catastrophe Evacuation				
	20.	Optional Benefit – Compassionate Visit				
	21.	Optional Benefit – Return of Minor Child				
	22.	Optional Benefit – Up-gradation to Business Class				
	23.	Optional Benefit – Daily Allowance				
	24.	Optional Benefit – Replacement of Staff				
	25.	Optional Benefit – Emergency Hotel Accommodation / Extension				
	26.	Optional Benefit – Out-patient Cover				
		a.1 Out-patient Care(this includes 'Pre-Existing Disease Cover In Life Threatening Medical Condition' for up to 10% of Sum Insured of Out-patient Cover); Or; a.2 Out-patient Care for Injury				
		b) Optional Extensions to Optional Benefit – Out-Patient Cover:-				
		i. Optional Extension 1 :Pre-Existing Disease Cover In Life Threatening Medical Condition				
		ii. Optional Extension 2 :Cancer screening & Mammography				
		iii. Optional Extension 3 : Treatment of Mental & Nervous Disorder				
		iv. Optional Extension 4 : Radiotherapy and Chemotherapy Charges				
		v. Optional Extension 5 : Vaccination Charges				
		vi. Optional Extension 6 : Non-emergency OPD consultation				
		vii. Optional Extension 7 : Adventure Sports Injury				
	27.	Optional Benefit – Hotel Cancellation				
	28.	Optional Benefit – Re-imbursement of Golf fees				
	29.	Optional Benefit – Home Care				
	30.	Optional Benefit – Maternity Cash Benefit				
	31.	Optional Benefit – Loss of Laptop/ Tablet / Hand baggage				
	32.	Optional Benefit – Non-Allopathic Treatments				
	33.	Optional Benefit – Parent Accommodation				
	34.	Optional Benefit – Health Check-up				
	35.	Optional Benefit – Bail Bond				
	36.	Optional Benefit – Sponsor Protection				
	37.	Optional Benefit – Study Interruption				
	38.	Optional Benefit – University Insolvency				
	39.	Optional Benefit – Additional Services				

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