care HEALTH INSURANCE

Proposal Form - 'Group Saral Suraksha Bima - Care Health Insurance'

URN: CHIL / G / PA / 095 / 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 :

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 (less costs of medical tests) 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 or this Proposal Form.
4. 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 person name :

Contact details of Key Contact person :

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

Correspondence: Address

Locality : City :

Pin Code : State :

Landmark :

Permanent: If same as above please tick here : ☐

Address

Locality : City :

Pin Code : State :

Landmark :

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

Mobile No. : Alternate 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 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 1.

Policy Details

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

Coverage Type : Individual

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

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 Insurer 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 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.

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 : / / 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 / Card / ECS (NACH)/Reward Points/Wallet/Any Other Mode (Strike out whichever is not applicable)

Premium payment mode : ☐ Single ☐ Monthly ☐ Quaterly ☐ Half-yearly (Tick whichever is applicable)

Cheque / Demand Draft No. / Authorization ID :

Date : / / Payment Amount (INR) :

Bank Name :

If ECS is selected, please submit the standing instruction form available at our branches.

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)

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)

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

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

Group Saral Suraksha Bima – Care Health Insurance - Annexure – I to Proposal Form- Enrollment Data (Illustrative)

Policy holder Name	Policy holder 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	Annual Income (in Rs.)	Are you Salaried or Self – employed	Nominee	Do you have ABHA No. ? If Yes, please mention

Optional Cover 1 – Temporary Total Disablement (TTD) : ☐ Yes ☐ No

Optional Cover2 - Hospitalization Expenses due to Accident : ☐ Yes ☐ No

Optional Cover3 – Education Grant : ☐ Yes ☐ No

If Yes, please provide details of children who shall avail this benefit

S.No.	Dependent Child Name	Age & DOB	Pursuing an Educational Course (Y/N)	Details of Education course

* This optional cover shall be available only to children who is pursuing education in an educational institution as a full time student. Any child to be included at later stage, the same can be done through endorsement

LIFESTYLE RELATED INFORMATION

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations or important political party officials.						
Does your job require you to be involved with any hazardous activity, significant manual labor, operating heavy machinery, handling hazardous material, working at heights/underground/construction sites, oil rigging, high voltage, high temperature, working in aircrafts or sea-going vessels or adventure sports or armed forces?						
Have you ever been diagnosed with or are you under treatment for any disability/deformity (impairment/infirmity/condition hampering vision, hearing or mobility) or any terminal illness or any illness or disease causing restriction to activities (E.g Epilepsy or Seizures)						
Under which of the following categories does your occupation fall? · Category 1: Persons engaged primarily in administrative functions · Category 2: Persons engaged in manual work other than Category 3. · Category 3: Persons working in explosives industry, mine and /or Magazine workers, high tension electric supply, horse racing including jockeys, athletes and occupations of similar hazard Please specify occupation if not in the above categories	☐ ☐ ☐ _____	☐ ☐ ☐ _____	☐ ☐ ☐ _____	☐ ☐ ☐ _____	☐ ☐ ☐ _____	☐ ☐ ☐ _____
Do you participate in Adventure/ extreme sports? If Yes, please provide the nature and frequency of adventure / extreme sport	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Has any company ever declined to issue/renew a Personal Accident policy for any proposed? If yes, please provide details	Yes ☐ No ☐ _____	Yes ☐ No ☐ _____	Yes ☐ No ☐ _____	Yes ☐ No ☐ _____	Yes ☐ No ☐ _____	Yes ☐ No ☐ _____

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