care HEALTH INSURANCE

URN.: CHIL / G / PA / 102 / 22-23

Proposal Form - 'Group Secure'

Proposal No.:_____

1. 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.

To be filled by the Proposer. Please fill in CAPITAL only.

Proposer Details

Full name of the Proposer/Entity :

Address :

City :

State :

Pin Code :

E-mail :

Nature of Business :

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

Please provide complete details in the attached "Annexure A" for Persons to be insured.

Please provide maximum number of lives to be insured at each location. _____

_____(Please provide in a separate sheet, if space not enough)

Basis of Sum Insured : ☐ Fixed Sum Insured ☐ Sum Insured Based on Category/Earnings

If the benefits are based on Category/Earnings, please provide

I. Estimated annual salary and number of members in each category ii. Highest annual salary in the Entity

Details of Key Contact Person

Name :

Address :

City :

State :

Pin Code :

Landline : - Mobile :

E-mail :

Ver: Aug/23/AS

Past Policy and Claim Details

Please provide the particulars for at least past 3 policy periods. If the past policy period is less than 3 years then for the complete period for which policy is availed.

Policy Period (From – To) (DD/MM/YYYY)	Name & Address of the Insurer	Policy No.	Total Premium	Total Amount of claims (Paid + O/s)	Total No. of claims (Paid + O/s)	Total No. of Members (incl. Endorsements)	No. of accidental death claims
			₹	₹			
			₹	₹			
			₹	₹			

Is any of the following condition valid for your entity? If yes, provide details.

Condition	Yes/No	Name of Insurance Company	Address
Declined to continue your insurance	☐ Y ☐ N		
Not invited renewal of your policy	☐ Y ☐ N		
Imposed any restrictions or special conditions	☐ Y ☐ N		

Proposed Policy Details and Material Disclosures

Any additional information relevant to the policy applied for : _____

_____

_____

_____

_____

Optional Extensions 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:

Description	Sum Insured	Excess (if any)	Opted (Yes/No)
Optional Extension 1 - Insured Event - Temporary Total Disablement			
Optional Extension 2 - Insured Event - Permanent Total Disablement Improvement			
Optional Extension 3 - Insured Event - Permanent Partial Disablement Improvement			
Optional Extension 4 - Insured Event - Reconstructive Surgery			
Optional Extension 5 - Insured Event - Accidental Hospitalization			
Optional Extension 6 - Insured Event - Medical Extension			
Optional Extension 7 - Insured Event - Hospital Cash Allowance			
Optional Extension 8 - Insured Event - Repatriation of Mortal Remains			
Optional Extension 9 - Insured Event - Funeral Expenses			
Optional Extension 10 - Insured Event - Ambulance Service			
Optional Extension 11 - Insured Event - Children's Education			
Optional Extension 12 - Insured Event - Marriage Allowance			
Optional Extension 13 - Insured Event - Burns			
Optional Extension 14 - Insured Event - Fracture			
Optional Extension 15 - Insured Event - Home Modification			
Optional Extension 16 - Insured Event - Mobility Extension			
Optional Extension 17 - Disappearance			

Operative Time Required

(Please tick as per requirements) in case You have purchased Optional Extension 18 - On Duty Cover:

☐ Continuous (24 hours) ☐ During the course of employment

☐ During course of employment and within premises of the entity

Nature of location of the Proposed Insured Members

(Please tick as per requirements)

☐ Hilly terrain ☐ Coastal areas ☐ River side ☐ Deserts

☐ Others (Please Specify) _____

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 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 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.

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 Authorised Signatory : _____

Name and Designation : _____

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.

Proposed Coverage and Payment Details

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

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

Instrument No. :

Instrument Date :

Bank Name :

Amount (INR) :

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

For Office Use Only

Intermediary Name :

Intermediary Code : Intermediary RM Code :

Branch Code : Business Sector :

Care Health Branch Details

Sales Manager Name :

Client ID : Receipt ID :

SCOPE OF COVER
This Policy pays the Insured members in case of Accidental Death, Loss of limbs and eyes, Permanent Total Disablement, Permanent Partial Disablement. The Scope policy is worldwide.

SIGNIFICANT EXCLUSIONS
The following is an indicative list of exclusions from the cover under the Policy. The Policy does not cover losses arising out of Suicide, Self-Injury, Venereal Diseases, War and Nuclear Perils and Pregnancy. For a detailed set of exclusions, kindly refer the Policy.

OPTIONAL EXTENSIONS
In addition, certain Optional Extensions 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 or Prospectus.

Acknowledgement for Customer

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

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