Application No.:_____ KYC No.: _____

pnb MetLife

care HEALTH INSURANCE

PNB MetLife India Insurance Company Limited
Registered office: Unit No. 701, 702 & 703, 7th Floor, West Wing, Raheja Towers, 26/27 M G Road, Bangalore -560001, Karnataka. IRDA of India Registration number 117.
CI No. U66010KA2001PLC028883 Call us Toll-free at 1-800-425-6969
Website: www.pnbmetlife.com, Email: indiaservice@pnbmetlife.co.in or write to us 1st Floor, Techniplex -1, Techniplex Complex, Off Veer Savarkar Flyover, Goregaon (West), Mumbai - 400062. Phone: +91-22-41790000, Fax: +91-22-41790203

Care Health Insurance Limited
Registered Office Address: 5th Floor, Chawla House, Nehru Place, New Delhi-110019

Contact No. 1800 XXX XXXX
URN: RHICL/R/CO/39/19-20

Application Form

Please fill	Code	Name
IA/FPC/CSO /DM/ARM/ISP		
Specified Person		
PNB MetLife Branch		
Relationship Branch Name of CA/Broker /Referral Company /M I A		

Policy Type: ☐ Rural ☐ Urban
Channel Type: ☐ Agency ☐ Broker ☐ BABP ☐ DM ☐ IMF

Employee Discount:
☐ PNB Employee ☐ PNB MLI Employee
☐ J&K Bank Employee

Account Type:
☐ Small ☐ Normal ☐ Simplified (For low risk customers)

PROPOSED INSURED

Paste here (do not pin or staple)
* A recent passport size photograph (not more than 6 months old)

Intermediary Details:

Intermediary name:
Intermediary code:
Intermediary RM Code:
Branch code:
Customer Account No.:

Branch Details:

Relationship Manager Name:
Branch code:
Client ID
Receipt ID:

(The above details are for internal use only & are illustrative)

PLEASE NOTE:

1. To be filled in by the Proposer in CAPITAL LETTERS only.
2. The proposed policyholder will be referred to in this Proposal Form as "Proposer", "You" or "Your".
3. The insurers are 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 cost of medical tests) from you if any, will be refunded without interest.
4. 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.
5. Please read all the questions carefully and complete the details required truthfully in relation to your health and habits, within your knowledge as on the date of the submission of this application. The information provided by you will form the basis for issuance of the policy. Please ensure that you affix your signature in all the place as stated in certain place more than one signature is required. This is in your own interest. Application Form needs to be filled in BLACK Ink only. All documents submitted along with this the application form should be attested by the Proposed Insured and Proposed Holder. The Application form and all rights, obligations, and Liabilities arising thereunder, shall be construed, determined and enforced in accordance with the law of India. State code and Country code to be updated as per Indian motor vehicle, 1988 and ISO 3166 country code respectively Corrections or over writing, if any, mus bear full signature of the Applicant. The life insurance policy is neither a Fixed/Recurring deposit/mutual fund or surrogate of any of the loan products applied with the bank and not a pre-condition for opening a bank account/availing a loan or locker facilities etc. Participation for availing the insurance policy is purely on voluntary basis.

A. Proposed Insured Details (To be filled in BLOCK LETTERS and all FIELDS are mandatory)

1. Name (Mr./Mrs./Ms./Dr./Master/Other): (Same as ID Proof) FIRST MIDDLE LAST
2. Maiden Name (Ms./Dr./Other): FIRST MIDDLE LAST
3. Father's Name (Mr./Dr./Other): FIRST MIDDLE LAST
4. Mother's Name (Ms./Mrs./Dr./Other): FIRST MIDDLE LAST
5. Spouse Name (Mr./Mrs./Dr./Other): FIRST MIDDLE LAST
6. Date of Birth: DDMMYYYY
7. Place of Birth: (Include Country Name)
8. Gender: ☐ M-Male ☐ F- Female ☐ T- Transgender
9. Citizenship: ☐ IN- Indian ☐ Others-ISO 3166 Country Code ☐☐
10. Are you Tax resident of any other country other than India ☐ Yes ☐ No
    [If Yes, please fill up FATCA/ CRS questionnaire and fill point 13 (iii)]
11. Residential Status: ☐ Resident Individual ☐ Non Resident Indian ☐ Person of Indian Origin ☐ Foreign National _____ COUNTRY NAME
12. Marital Status: ☐ Married ☐ Unmarried ☐ Others (Specify) _____
13. (i) ☐ Current/Permanent/Overseas Address:
    Address Type: ☐ Residential/Business ☐ Residential ☐ Business ☐ Registered Office ☐ Unspecified
    Address Proof: ☐ Passport ☐ Driving License ☐ Voter Identity Card ☐ NREGA Job Card ☐ Simplified Measures Account – Document Type Code ☐☐
    Others_____ (Certified copy of anyone of the following Proof of Address [PoA] needs to be submitted)

LANDMARK
DISTRICT
CITY/TOWN/VILLAGE
PIN/POSTCODE
STATE/UTCODE

(ii) ☐ Correspondence/Local Address

☐ Same as Current/Permanent/Overseas Address (In case of multiple Correspondence/Local Address, please fill annexure A1)

LANDMARK | CITY / TOWN / VILLAGE

DISTRICT | PIN / POSTCODE | STATE / UTCODE

(iii) ☐ Address in the Jurisdictions details where applicant is Resident Outside India for tax purposes

☐ Same as Current/Permanent/Overseas Address ☐ Same as Correspondence/Local Address

LANDMARK | CITY / TOWN / VILLAGE

DISTRICT | PIN / POSTCODE | STATE / UTCODE

14. Telephone Office: (Country Code / Area/STD Code / Telephone) Mobile Email

Telephone Residence: (Country Code / Area/STD Code / Telephone) Fax (Country Code / Area/STD Code / Telephone) Alternate Mobile No.

15. ☐ PAN No. ☐ Form 60:

16. Educational Qualification: ☐ Post Graduate and Above ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ 10th Pass ☐ Below 10th Pass ☐ Illiterate ☐ Others (Specify)

17. Occupation: ☐ S- Service (☐ Private Sector ☐ Public Sector ☐ Government Sector ☐ Others)

☐ O- Others (☐ Professional ☐ Self Employed ☐ Retired ☐ Housewife ☐ Student) ☐ B- Business ☐ X- Not Categorised

18. Occupation Details: **19.** Additional KYC#: **20.** Income Proof: **21.** Age Proof*:

#Name of additional documents submitted if Proposed Owner is a Trust or Foundation OR Type of Cover is selected as Employer-Employee/ General Partnership/ Key Partnership/ Key Person.

Name & Address of the Organization/Business	Nature of Business	Exact Nature of Duties	Designation	Years of Service/Business	Annual Gross Income (in Rs.)

*In case of Non Standard Age Proof like Voter ID Card, Ration Card, etc. extra of Rs. 2.50 per thousand sum assured will be charged. Applicable for life Insurance.

22. Identity Proof: (Certified copy of anyone of the following Proof of identity [Pol] needs to be submitted)

☐ A- Passport No. Passport Expiry Date (DD/MM/YYYY) ☐ B- Voter ID Card

☐ C- PAN No. ☐ D- Driving License Driving License Expiry Date (DD/MM/YYYY)

☐ F- NREGA Job Card ☐ Z- Others (any document notified by the central government)

☐ S- Simplified Measures Account - Document type code ☐☐ Identification No.

23. Purpose of Insurance: ☐ Planning for Child's future ☐ Protection ☐ Saving ☐ Key person ☐ Retirement ☐ Gift of Life ☐ Others (Specify)

24. Do you wish to register Email id on which you will receive communication through Email, we shall stop sending Policy related communication to you in physical form. ☐ Yes ☐ No

B. Details of persons proposed to be insured

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name First Name						
Last Name						
Date of Birth (DD/MM/YYYY)						
Gender (M/F/T)	☐ M ☐ F ☐ T	☐ M ☐ F ☐ T	☐ M ☐ F ☐ T	☐ M ☐ F ☐ T	☐ M ☐ F ☐ T	☐ M ☐ F ☐ T
Relationship with Proposer						
Marital Status						
Nominee (Relationship with Insured)						
City of Residence						

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Profession / Occupation :-						
• Self Employed	☐	☐	☐	☐	☐	☐
• Service						
◦ Sales	☐	☐	☐	☐	☐	☐
◦ Manufacturing	☐	☐	☐	☐	☐	☐
◦ Others	☐	☐	☐	☐	☐	☐
• House-spouse	☐	☐	☐	☐	☐	☐
• Student	☐	☐	☐	☐	☐	☐
• Retired	☐	☐	☐	☐	☐	☐
• Not Employed	☐	☐	☐	☐	☐	☐
• Other (Please specify)						
Annual Income (in Rs.)						
Height (in centimeters)						
Weight (in kilograms)						

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Are you or your family member/close associate is politically exposed person (PEP*). If yes please fill the PEP Questionnaire.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

* Individuals who are or have been entrusted with prominent public functions domestically or by a foreign country , which may include Heads of State or of government, senior politicians (Members of Political parties contested in elections of Local bodies/Legislature/Parliament or Nominated), senior government (All Secretary levels), judicial or military officials (Ranks Equivalent to Major and above), senior executives of state owned corporations, important political party officials. Individuals who are or have been entrusted with a prominent function by an international organization, refers to members of senior management or individuals who have been entrusted with equivalent functions, i.e. directors, deputy directors and members of the board or equivalent functions.Family members are individuals who are related to a PEP either directly (consanguinity) or through marriage or similar (civil) forms of partnership. Close associates are individuals who are closely connected to a PEP, either socially or professionally.

C. Medical, Lifestyle and Personal details of the Proposed to be insured

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1. Has any Proposed to be Insured been diagnosed with or suffered from / is suffering from any medical condition, sickness or disability? If the answer is Yes, please provide specific response to following questions (i to xi) and provide more details:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. Cancer, tumor, polyp or cyst	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
ii. Any cardiovascular/Heart Disease or disorder (including but not limited to Coronary artery disease / Rheumatic heart disease / Heart Attack or Myocardial infarction / Heart failure / Bypass Grafting or CABG / Angioplasty or PTCA / Heart valve diseases / Pacemaker implantation)/ chest pain or discomfort, irregular heartbeats, palpitations or heart murmur	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
iii. Hypertension/ High Blood Pressure(BP)/High cholesterol	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
iv. Any Respiratory disease / Disease of Lungs, Pleura and airway (including but not limited to Asthma / Tuberculosis / COPD/ Pleural effusion / Bronchitis / Emphysema)	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
v. Any disorders of the endocrine system (including but not limited to Pituitary tumor / Thyroid disease/ Cushing's disease/ Parathyroid disease / Addison's disease/ adrenal gland disorders)	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
vi. Diabetes Mellitus/ High Blood Sugar/ taking insulin or any other medication	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
vii. Any Neuromuscular (muscles or nervous system) disorder or Psychiatric disorders (including but not limited to Motor Neuron Disease, Muscular dystrophies, Epilepsy, , Myasthenia Gravis, Transient Ischemic Attack, Alzheimer's, Depression , Dementia, Paralysis, Parkinsonism, multiple sclerosis, stroke, mental illness) or any other disease of Brain and Nervous System?	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
viii.Pancreatitis or Liver disease (including but not limited to Cirrhosis / Hepatitis / Wilson's disease/ Crohn's disease / Ulcerative Colitis /Piles) or any other digestive track disorder (disorders of esophagus or stomach, Liver, Gall bladder or intestine or any other)	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
ix. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs?	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
x. Any disorders of Blood / Bone marrow / Immunity or skin (including but not limited to bleeding or clotting disorders, HIV, Scleroderma, Psoriasis Systemic Lupus Erythematosus, Rheumatoid Arthritis, Crohn's disease, Ulcerative Colitis).	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
xi. Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses)?	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
xii. Any other disease / health adversity / condition / treatment not mentioned above?	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months	☐ Yes ☐ No If Yes, Months ....
2. Do You consume Tobacco, alcohol or any recreational drugs? If 'Yes' then please provide the following details:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. Tobacco ☐ Cigarattes ☐ Bidi ☐ Gutkha ☐ Cigar ☐ Others_____________	☐ Yes ☐ No If Yes, i. No. of sticks/ packets per day______ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, i. No. of sticks/ packets per day______ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, i. No. of sticks/ packets per day______ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, i. No. of sticks/ packets per day______ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, i. No. of sticks/ packets per day______ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, i. No. of sticks/ packets per day______ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________
ii. Alcohol ☐ Hard Liquor ☐ Beer ☐ Wine	☐ Yes ☐ No If Yes, i. No. of pint/ml per week ___________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, i. No. of pint/ml per week ___________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, i. No. of pint/ml per week ___________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, i. No. of pint/ml per week ___________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, i. No. of pint/ml per week ___________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, i. No. of pint/ml per week ___________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________
iii. Narcotics/ Drugs ☐ Marijuana ☐ Cocaine ☐ Others ______________	☐ Yes ☐ No If Yes, I. Quantity __________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, I. Quantity __________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, I. Quantity __________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, I. Quantity __________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, I. Quantity __________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________	☐ Yes ☐ No If Yes, I. Quantity __________ ii. Duration (months) ________ iii. If Stopped consuming, state date when you stopped ________
3. Has any of the Proposed to be Insured been hospitalized or has been under any prolonged treatment for any illness/injury or has undergone surgery other than for childbirth/minor injuries?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Has any of the Proposed to be Insured consulted/taken treatment or recommended to take investigations/medication/surgery other than for childbirth/minor injuries?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
5. Is your occupation associated with any specific hazards (E.g. Mines, Explosives, Corrosive Chemicals and HTV Drivers, etc), please complete the respective Occupation Questionnaire?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Are you employed in Armed, Para Military or Police Force, if Yes, please complete Armed Services Questionnaire?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you ever been convicted of a criminal offence or do you have any criminal case or charge pending against you?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Have you flown in the last two years or do you expect to fly in future either as a Student Pilot, Pilot, Crew Member Passenger in a Non-Commercial/ Personal / Chartered Flight? If yes, please complete Aviation Questionnaire. (Please tick "No" if you are a fare-paying passenger in domestic/international airline)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. Do you engage in Automobile or Motor-cycle Racing, Skin or Scuba Diving, Skydiving or Professional Sports? If yes, please complete respective Avocation Questionnaire.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

For Female Proposed Insured Only

1) Are you Pregnant? ☐ Yes ☐ No If yes, please mention current months of pregnancy. ☐ Less than or equal to 6 months ☐ More than 6 months
If any complications relating to pregnancy please give details._____

2) Have you delivered, undergone caesarian section, had any abortion or miscarriage? ☐ Yes ☐ No If yes, please mention the period elapsed since the last occasion
☐ In last 3 months ☐ 3 to6 months ☐ More than 6 months

3) Have you suffered / are suffering from any disorder of the breast or reproductive organs? ☐ Yes ☐ No If yes, please provide details_____

Additional information (if your answer is 'YES' to any of the above questions or the proposed to be insured are suffering from any other pre existing disease which is not mentioned in the above list

D. Nominee details (To be filled if Proposed Insured and Proposed Holder are the same) and Appointee details - To be filled only if the Nominee is a minor. (The Appointee must not be the Proposed Insured)

Nominee details

1. Name (Mr./Mrs./Ms./Dr./Master/Other) F I R S T M I D D L E L A S T
2. Date of Birth D D M M Y Y Y Y 3. Gender ☐ Male ☐ Female 4. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
5. Nationality: ☐ Indian ☐ Non-Resident Indian ☐ Person of Indian Origin ☐ Foreign National_____(Country Name)
(If Non-Resident Indian or People of Indian Origin or Foreign National, please mention the country you reside in the space provided above and complete NRI/PIO/Foreign National questionnaire)
6. Relationship with the Proposed Insured_____ 7. % Nominee Share** ☐☐☐ % **In case of more than one nominee, please fill respective share of nomination in multiple nominee form

Appointee details

1. Name (Mr./Mrs./Ms./Dr./Master/Other) F I R S T M I D D L E L A S T
2. Date of Birth D D M M Y Y Y Y 3. Gender ☐ Male ☐ Female 4. Marital Status ☐ Single ☐ Divorced ☐ Widowed
5. Nationality: ☐ Indian ☐ Non-Resident Indian ☐ Person of Indian Origin ☐ Foreign National_____(Country Name)
(If Non-Resident Indian or People of Indian Origin or Foreign National, please mention the country you reside in the space provided above and complete NRI/PIO/Foreign National questionnaire)
6. PAN No. ☐☐☐☐☐☐☐☐☐☐ 7. Signature Accepting the Appointment_____ 8. Relationship with Nominee _____

E. Details of existing or previous Health & life Insurance Policies
(In case the Proposed Insured is a minor/student provide the following details for the entire family. In case Proposed Insured is house wife provide the following details of husband.)

Type of Insurance	Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Health Insurance	Have any of the person(s) to be insured ever filed a claim with their current/ previous insurer? If Yes, please provide details in the space given below for "Additional Details"	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Has any of your proposal(s) for Health insurance been declined, cancelled or charged a higher premium or issued with special condition(s)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company or any other Company without break?	☐ Yes ☐ No Since_____ DD/MM-YYYY	☐ Yes ☐ No Since_____ DD/MM-YYYY	☐ Yes ☐ No Since_____ DD/MM-YYYY	☐ Yes ☐ No Since_____ DD/MM-YYYY	☐ Yes ☐ No Since_____ DD/MM-YYYY	☐ Yes ☐ No Since_____ DD/MM-YYYY
Life Insurance	Relationship with Proposed Insured (Self, family member)		NA				
	Name of the Insurance Company						
	Type of Policy						
	Existing Policy SA/ Face Amount (Rs.) Base +Term Rider						
	Annualised Premium						
	Year of Issue						
	In force/ lapsed/in case of revival, date of revival/pending						
	Acceptance terms (Std./ with extra/ postponed/ declined/ withdrawn /restricted benefits)						

Aditonal Details

F. Product Details

I. Life Insurance

1.

Product Name	Policy Term	Premium Payment Term	Basic Sum Assured	Premium Multiple

Plan/ Benefit Option:_____ Cover Option:_____

Monthly Income:_____ Return of Premiums: ☐ Yes ☐ No

Frequency of premium payment: ☐ Yearly ☐ Half Yearly ☐ Quarterly ☐ Monthly

** Preferences for Renewal Premium Payment Mode: ☐ Cash^ ☐ Cheque##/DD# ☐ Online Payment^^ ☐ Direct Debit/ACH* ☐ PSP ☐ PNB-Auto Debit ☐ J&K Bank Auto Debit ☐ KBL Auto Debit ☐ Others (Specify)_____ *Please fill in the relevant Standing Instruction Form. ^All Premium payment in cash has to be made directly at our nearest branch. Our agents are not authorized to collect the premium in cash. ^^Payment can be made through Debit/ Credit Card/ NEFT

**The premium shall be adjusted on the due date even if it has been received in advance & If premium due in one financial year is being collected in advance in earlier financial year, insurers may collect the same for a maximum period of three months in advance of the due date of the premium.

II. Health Insurance

Plan Opted :

Sum Insured (in Rs.):

Tenure: ☐ 1Year ☐ 2Years ☐ 3Years

Cover Type : ☐ Individual ☐ Floater

Optional Cover – 1 : Global Coverage – Total opted : ☐ Yes ☐ No

Optional Cover – 2 : Travel Plus opted : ☐ Yes ☐ No

Optional Cover – 3 : Unlimited Automatic Recharge opted : ☐ Yes ☐ No

Optional Cover – 4 : No Claim Bonus Super opted : ☐ Yes ☐ No

Optional Cover – 5 : Deductible Option opted : ☐ Yes ☐ No

If Yes, then please mention Deductible (in Rs.):

Optional Cover – 6 : Everyday Care opted : ☐ Yes ☐ No

Optional Cover – 7 : Smart Select opted : ☐ Yes ☐ No

Optional Cover – 8 : OPD Care opted : ☐ Yes ☐ No

If Yes, then please mention the amount opted *(in Rs.):*

Optional Cover – 9 : Daily Allowance+ opted : ☐ Yes ☐ No

If Yes, then please mention the amount opted (in Rs.):

Optional Cover – 10 : Personal Accident opted : ☐ Yes ☐ No

If Yes, then please fill the following details:-

(i) Amount opted for the Proposer *(in Rs.):*

(ii) Additional Persons to be covered : ☐ Spouse ☐ Children

(iii) 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? : ☐ Yes ☐ No

Optional Cover – 11 : Additional Sum Insured for Accidental Hospitalization opted : ☐ Yes ☐ No

Optional Cover – 12 : International Second Opinion opted : ☐ Yes ☐ No

Optional Cover – 13 : Reduction in PED Wait Period opted : ☐ Yes ☐ No

Optional Cover – 14 : Extension of Global Coverage opted : ☐ Yes ☐ No

Optional Cover – 15 : Air Ambulance Cover opted : ☐ Yes ☐ No

Are you applying for portability? ☐ Yes ☐ No (If yes, please fill in the separate Portability Form)

Premium Details

1) Life Insurance: Annual Premium amount Rs._____ 2) Health Insurance: Premium amount Rs. _____

Attending Physician's details

Name of the family physician:_____ Contact number:_____ E-mail id: _____

G. Additional Information

1. Details of Initial Deposit Type of Deposit ☐ Crossed Cheque## ☐ Bank Draft# ☐ Cash ☐ Online Payment** ☐ PNB-Auto Debit ☐ J&K Bank Auto Debit

Instrument No. Instrument Date :_____ Amount in (Rs.)_____ Name of the Bank & Branch : _____

2. Premiums will be paid by ☐ Proposed Insured ☐ Proposed Holder ☐ Others*(Specify)_____ *Please fill third party declaration form

If other, please provide the following details. Name Relationship to Proposed Holder Annual Income of the Premium Payor

3. ☐ PAN No. of Third party: ☐ Form 60 of Third party:

4. Account type of PO ☐ Saving ☐ Current ☐ NRE ☐ NRO

5. ^Account No. of PO: MICR Code: IFSC Code:

PO Bank & Branch Name :_____ *Cheque/DD payable to "PNB MetLife India Insurance Company Limited" or "Religare Health Insurance Company Limited". Application/Policy no. Details will be used for all payouts by the insurers.

##Cheque subject to realization. **Payment can be made through Debit/ Credit Card/ NEFT. ^Bank Proof (Pre-Printed Cancelled Cheque / Bank Account Statement) to be mandatorily submitted.

H. E-Repository Details

If you already have an e-Insurance Account (e-IA) number, kindly provide ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If you don't have an e-Insurance Account (e-IA), please choose any one of the following

☐ CAMSRep - CAMS Insurance Repository & Services ☐ NDML - NSDL Data Management Services limited

☐ KARVY ☐ CIRL - Central Insurance Repository Limited

Key Exclusions :

(i) Any disease contracted during the first 30 days of the policy start date, except those arising out of accidents.

(ii) 2 Year Wait Period : Non-infective arthritis/Joint replacement/Cataract/Piles/Fissure/Ear, nose and throat (ENT) disorders and surgeries/Stones, etc.

(iii) Pre-existing Diseases : 48 months (24 months, if opted for Optional Cover 'Reduction in PED Wait Period') from the date of the first policy

(iv) Permanent Exclusions : Expenses attributable to self-inflicted injury (resulting from suicide, attempted suicide) or alcohol or drug use, misuse or abuse / Cost of spectacles, contact lenses.

(v) Treatment/consultation in a hospital which is named in the negative list of hospitals.

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

I. Tax Status Questionnaire (To be filed by Proposed Holder)

Do you have an / a:

1. United States citizenship or resident status (resident status applies in the event of the Applicant being an individual or an entity created, incorporated or governed by United States Laws): ☐ Yes ☐ No
2. US place of birth: ☐ Yes ☐ No
3. US telephone number: ☐ Yes ☐ No
4. US residence or correspondence address (including a US PO Box): ☐ Yes ☐ No
5. Standing instructions to transfer funds to a US account: ☐ Yes ☐ No

In the event of the any of the questions being answered as Yes, please furnish the following:

1.If the Applicant is subject to United States Federal Income Tax please provide the Applicant's U.S. Tax ID Number(s)* or a W-9

2.If the Applicant is not subject to United States Federal Income Tax please provide a self-certification under perjury, and a Non-US passport or other valid government-issued identification evidencing citizenship in a country other than the US or such other forms or declarations as may be informed to you by the Company.

IN CASE OF AN APPLICANT NOT CURRENTLY HAVING US INDICIA, THE APPLICANT AGREES TO INFORM THE COMPANY WITHIN THIRTY (30) DAYS OF THE APPLICANT'S KNOWLEDGE OF SUCH CHANGE IF THE APPLICANTACQUIRES US INDICIA.**

*If the Applicant(s) is subject to United States Federal Income Tax and fails to provide a U.S. Tax Identification Number to the Company, the Internal Revenue Service requires the Company to withhold tax from taxable income payments made to the Applicant.

**US indicia (United States Indicia) is defined as any individual or entity who exhibits any of the following:

1. United States citizenship or resident status (applicable to an entity by virtue of being created, incorporated or governed by United States Laws);
2. US place of birth;
3. US telephone number;
4. US residence or correspondence address (including a US PO Box); or
5. Standing instructions to transfer funds to a US account.

J. Declaration

1. I am aware that the product is jointly offered by PNB MetLife India Insurance Company Limited and Care Health Insurance limited (hereinafter jointly referred to as 'Insurers').
2. I am aware that the coverage under Life Insurance section is offered by PNB MetLife India Insurance Company Limited and coverage under Health Insurance section is offered by Care Health Insurance limited.
3. I am aware that each section of the policy is serviced by two different insurers namely PNB MetLife India Insurance Company Limited and Care Health Insurance Limited.
4. I am aware that claim under Life Insurance section will be serviced and settled by PNB MetLife India Insurance Company Limited and claim under Health Insurance Section will be serviced and settled by Care Health Insurance Limited.
5. I am aware that the legal / quasi legal disputes, if any, are dealt by the respective Insurers for respective benefits.
6. I am aware that I am eligible to continue with either part of the policy, discontinuing the other during the policy term at the point of payment of annual premium.
7. Reinstatement of Health benefit will not be allowed. However, Life benefit may be revived during the revival period as per the applicable terms and conditions.
8. I am aware that, wherever guaranteed renewability of health insurance plan is allowed, only the Health Section of the Product is entitled to that facility.
9. I am aware that premium for the Product shall be paid annually.
10. I am aware that this is a Combi product and a discount of 7.5 % on annual premiums paid towards both Life & Health will be offered as compared to the individual policy purchased under Life & Health. At any time during the validity of the policy, if I decide to opt out of the insurance coverage of one of the Insurer, the discount, if any, being offered under the Combi-Product(s) shall not be available.
11. I am aware that PNB MetLife India Insurance Company Limited will be the nodal point for policy servicing. Any queries relating to the coverage under the policy shall be obtained by contacting the Toll Free Number 1-800-425-6969 and Fax: +91-22-41790203
12. I am aware that I should contact, in case of any grievance :

a. For Health Section: Care Health Insurance Limited.

b. For Life Section : PNB MetLife India Insurance Company Limited

13. I have made myself familiar with the Policy benefits and policy service structure of the Product before deciding to purchase the Policy.

I have read this Application or got read/ explained the Application, and furnished the information, after fully understanding the contents thereof. I have made complete, true and accurate disclosure of all facts to the best of my knowledge and belief and that I have not withheld any information. I hereby declare, on my behalf and on behalf of the 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 their behalf. I understand that the information provided by me form the basis of the insurance policy and that the policy is subject to the respective Board approved underwriting policies of the Insurers and that the cover will come into force and effect only after full receipt of the premium chargeable and upon issuance of the policy.

I declare that I consent to the Insurers seeking medical information from any doctor or hospital who/which at any time has attended on the persons to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the persons to be insured/proposer and seeking information from any insurer to whom an application for insurance on the persons to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement. I authorize the Insurers 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 further consent, and authorize, the Insurers to use and disclose any of the personal and sensitive information of the insured/ proposer collected or available with the Insurers (whether contained in this application or obtained otherwise) which may include KYC documents to any individual/organisation/entity associated or affiliated with or engaged by the Insurers, including reinsurers, claim investigative agencies, vendors and industry associations/federations, for the purpose of processing/underwriting this application and/or providing subsequent services which will include services arising out of the insurance contract, including claims settlement.

AGREEMENT :

1. I do hereby agree that: 1.My answers and/or statements provided herein and this declaration shall form the basis of policy issued.
2. I do hereby agree that information provided by me shall be the basis of insurance contract between me and the Insurers.
3. If there is any suppression or mis-representation of material information or if any untrue statement is contained therein or in case of fraud, the said contract shall be treated as null and void in accordance with the provisions of the Section 45 of the Insurance Laws (Amendment) Act, 2015 and as amended from time to time.
4. If, after submission of this Application and before issue of the policy; (i) there are any adverse circumstances connected with the general health of the Proposed Insured/Proposed Holder or (ii) an application for insurance on the life of the Proposed Insured/Proposed Holder made to any other insurance company or an application of revival, has been withdrawn or dropped or accepted at an increased premium or on terms other than as originally proposed or (iii) there is any change in my/our occupation or financial position, I shall forthwith intimate the same to the Insurers in writing to reconsider the terms of acceptance of this Application. Any material omission on my part to do so shall render the contract based on this Application invalid and the policy shall be treated in accordance with the provisions of the Section 45 of the Insurance Laws (Amendment) Act, 2015 and as amended from time to time.
5. The payment made along with the application is a deposit with the Insurers to be adjusted towards premium in the event of acceptance of the risk sought to be insured by me. Unless accepted, no risk shall attach to the Insurers. In the event that the Application is found acceptable, the Insurers shall be entitled to issue the policy commencing from any date subsequent to the date of submission of the Application by me. I and the persons to be insured agree to undergo all medical tests required by the Insurers as per their guidelines, including HIV-Elisa Test.
6. I hereby declare that the money used by me to pay the premium under this Application has not been derived from any criminal or illegal activity or any unknown sources.
7. I hereby acknowledge that the information provided under this Application will be used for the purpose of underwriting this Application and for providing policy related services, in the event of the risk being accepted by the Insurers.
8. I further agree and consent to the Insurers receiving my/our updated address from CERSAI (which will happen on my/our updating the new address in my/our account maintained with any Bank or other financial Institution) and update the new address in my/our policy/ies with the Insurers. I also agree and consent to the Insurers sending future communications regarding my/our Policy/ies and other related services in the said updated address.
9. The policy will lapse in case the premium is not paid as per the payment terms opted.
10. I also understand that, the terms and conditions including the premium and the benefits payable under the Policy are subject to variation basis the change in applicable taxation and other relevant in accordance to applicable laws from time to time.

Signature / Left Thumb Impression of the Proposed Holder _____

Name of the Proposed Holder: _____

Signature of the Witness:_____Address of Witness: _____

(Witness should not be related to the Proposed Insured / Proposed Holder) Date:_____Place:_____

Name of Witness: _____

DECLARATION IN CASE OF VERNACULAR (Can not be signed by sales person or nominee)

Declaration by the person filling in the Application. (In case the Application is filled up / signed in a language different from that of the Application form.)

I hereby 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 Insurers. 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.

Declarant's Name_____Address _____

Date	Place	Signature of Declarant (on behalf of all proposed to be insured under the policy)	Signature/ Left Thumb Impression of Proposed Holder/ Proposed Insured

DECLARATION IN CASE THE APPLICANT IS ILLITERATE (Can not be signed by sales person or nominee)

In case the Applicant is illiterate, a person of standing, unconnected with PNB MetLife and Care Health Insurance, but whose identity can easily be established, should give the following declaration after attesting left thumb impression of the Applicant

I hereby declare that I have explained the contents of this Application in_____language to the Applicant. The same have been fully understood by him/her and replies have been recorded as per the information provided by the Applicant and the replies have been read out to and fully understood by and confirmed by the Applicant. The Applicant has affixed his/her left thumb impression in my presence.

Declarant's Name_____Address _____

Date	Place	Signature of Declarant	Signature/ Left Thumb Impression of Proposed Holder/ Proposed Insured

Section 45 of the Insurance Act, 1938 (applicable for Life Insurance) :

1. No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy i.e. from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later.
2. A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud; provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured, the grounds and materials on which such decision is based. For the purposes of this sub-section, the expression 'fraud' means any of the following acts committed by the insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
   a. The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
   b. The active concealment of a fact by the insured having knowledge or belief of the fact;
   c. Any other act fitted to deceive; and
   d. Any such act or omission as the law specifically declares to be fraudulent.

   Mere silence as to facts likely to affect the assessment of risk by the insurer is not fraud, unless the circumstances of the case are such that regard being had to them, it is the duty of the insured or his agent, keeping silence to speak, or unless his silence is, in itself, equivalent to speak.

   For complete details of the section and the definition of 'date of policy', please refer Section 45 of the Insurance Act, 1938, as amended from time to time.

STATUTORY WARNING as per Section 41 of the Insurance Act, 1938:

(1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take 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 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 prospectus 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.

ACKNOWLEDGEMENT

Application No.:_____ KYC No.: _____

PNB MetLife India Insurance Company Limited
Registered office: Unit No. 701, 702 & 703, 7th Floor, West Wing, Raheja Towers, 26/27 M G Road, Bangalore -560001, Karnataka.
IRDA of India Registration number 117.
CI No. U66010KA2001PLC028883 Call us Toll-free at 1-800-425-6969
Website: www.pnbmetlife.com, Email: indiaservice@pnbmetlife.co.in or write to us 1st Floor, Techniplex -1, Techniplex Complex, Off Veer Savarkar Flyover, Goregaon (West), Mumbai - 400062. Phone: +91-22-41790000, Fax: +91-22-41790203

Care Health Insurance Limited
Registered Office Address: 5th Floor, Chawla House, Nehru Place, New Delhi-110019
Contact No.: 1800 XXX XXXX
URN: RHICL/R/CO/39/19-20

"A/c Payee" Cheque/Draft should be drawn in favour of PNB MetLife India Insurance Company Limited or Care Health Insurance only.

PI/PO Name :	Insurance Agent/ Broker/ Specified Person Name and Code :

Corporate Agent Name:

Amount (In figures) :_____ Amount (In words) :_____

Premium Payment Option: Cheque ☐ Bank Draft ☐

Cheque/Draft No. :	Bank Name :	Cheque/Draft Date :

IMPORTANT:

1. All receipts/ Negotiable instruments are subject to realization.
2. Acceptance of Risk is subject to policy terms & conditions.
3. For Unit Linked Policies, the NAV would be allocated as per the date and time of, premium payment information being received by PNB MetLife from customer directly or through vendors. If the information is received before 3:00 PM on a business day, the same day's NAV is applicable and for other's NAV for the next business day shall be applicable.
4. Premium paid before policy due date will be allocated on policy due date.
5. Premium paid within 180 days of due date will be allocated on next business day of premium paid date.
6. Premium paid in lapsed policy after 180 days of due date, will be allocated on completion of all re-instatement requirements and reviewed by PMLI.
7. All Premium payment in cash has to be made directly at our nearest branch. Our agents are not authorized to collect the premium in cash.
8. This can be used only for collecting the initial premium and cannot be used for renewal premium collection.

Beware of spurious phone calls and fictitious/fraudulent offers

IRDA of India clarifies to public that

1. IRDA of India or its officials do not involve in activities like sale of any kind of insurance or financial products nor invest premiums.
2. IRDA of India does not announce any bonus. Public receiving such phone calls to lodge a police complaint along with details of phone call and number.

Signature of Agent/ Broker/ Specified Person:_____ Seal/ stamp of the Broker/ Corporate Agent:_____ Date: _____