

senior health advantage

Proposal Form

Proposal No.:__

- 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.

4. The proposed policyholder will be referred to in this Proposal Form as "Pro	poser", "You" or "Your".								
PROPOSER DETAILS									
Name : (Mr./Ms./Mrs.)									
· · · · · · · · · · · · · · · · · · ·	(First Name)		(Mide	dle Name)		(Last Name)			
Correspondence Address :									
Locality:			С	ity:					
Pin Code :		Sta	ite:						
Landmark:									
Permanent Address :									
If same as above, please tick here									
Locality:			C	iity:					
Pin Code :		Sta	ate:						
Landline (Residence):			P	1obile No*.:					
Alternate No :									
*The registered mobile number will be enrolled for Wha	tsApp notifications re	elated to your	Care Health In	surance Policy 😥					
Email:									
Date of Birth / Incorporation (in case Proposer is an entit	ty) : D D M M	1 Y	Y	Gender: Male	Female	Others			
Marital Status : Single Mar	rried	Divorce	ed	Widow(er)	Separated				
Mother's Name :									
PAN Number:			Nationality:	Indian Othe	er than Indian				
Form 60 (only in case the customer does not have PAN no.) :	Yes	No	Aadhaar Num	ber(last 4 digits):	$\times \times \times \times \times$				
Please share the following for authentication purpose:			(By signing the Proposal form	n I give my consent for using my Aadhaa	ar No. for Authentication of my Aadhaar D	Netails)			
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Proof of Identity (POI) (Tick whichever is app	olicable)								
PAN Aadhaar Passport Dr	riving License V	oter ID Card							
Letter from a recognized public authority or public servant v	verifying the identity an	nd residence c	of the Proposer						
Proof of Address (POA)	nichever is applicable)								
Electricity bill (not older than 3 months)	haar Pass	port	Ration	Card	Driving License				
Telephone Bill (not older than 3 months) Bank Account Statement (not older than 3 months)									
Letter from a recognized public authority or public servant verifying the identity and residence of the Proposer									
Would you like to opt for Electronic Policy Issuance through: If you have an elA, please provide following details:	an e-Insurance Accour	nt (eIA) of an I	Insurance Repos	itory?	Yes	No			
Name of Insurance Repository:									
II) elANo:									
III) Name as appearing in eIA:									
If you do not have an eIA, would you like to open an account:	? Ye	es	No						
If Yes, choose any one Insurance Repository:									
☐ CAMSRep−CAMS Insurance Repository & Services	□ NDML−NSDL Data Management Limited								
□ KARVY Insurance Repository Limited □ CIRL−Central Insurance Repository Limited									
Help us preserve the environment by opting to receive policy decreases decreas	ry related information in	n soft copy/vi	a email only :	Yes	No				

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Page	Plan:																							
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Insured 1 Name Mr/Ms/Mrs	Are you applying	for porta	bility?	1	Yes 🗌		No [] (It	yes, plea	se fill in t	he separa	ate Po	rtabilit	y Form)										
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Treated / Taken Medication for any of the following conditions: If yes, please provide details in the additional information section below: 1. Cancer, tumor, polyp or cyst 2. Any heart disease or disorder, chest pain or discomfort, irregular heartbeats, palpatations or heart murmur 3. Hypertension / High Blood Pressure (BP) / High Cholestrol	Particulars							Insu	red I	Insu	red 2	l li	nsure	d 3	Insu	ıred 4	In	sured	5	In	sur	ed 6		
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4. Asthma / Tuberculosis (TB) / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease?	Since	Y N Since	Since	Since	Since	Since
5. Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pitutiary tumor/ disease or any other disorder of Endocrine	Y N	Y N Since	Y N Since	Y N Since_	Y N Since	Y N Since_
system? 6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since
7. Motor Neuron Disease/ Muscular dystrophies/ Myasthnia Gravis Demyelinating disease or any other disease of Neuromuscular system (muscles and/or nervoussystem)	Y N Since	Y N Since	Y N Since	Since N	Y N Since	Y N Since
Stroke/ Paralysis/ Transient Ischemic Attack/ Multiple Sclerosis/ Epilepsy/ Mental-Psychiatric illness/ Parkinsonism/ Alzeihmer's/ Depression / Dementia or any other disease of Brain and Nervous System?	Y N	Y N Since	Y N Since	Y	Y N Since	Y N Since
9. Cirrhosis / Hepatitis / Wilson's disease / Pancreatitis / Liver disease / Crohn's disease / Ulcerative Colitis //Inflammatory Bowel Diseases/ Piles or any other disease of Mouth, Esophagus, Liver, Gall bladder, Stomach or Intestines or any other part of Digestive System?	Y N Since_	Y N Since_	Since_	Y N Since_	Since	Y N Since_
10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs?	Y N Since	Since	Y N Since_	Y N Since	Since	Y N Since
Sarcoidosis/ Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin.	Y N	Y N Since	Since	Since	Y N Since	Y N Since
Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses)?	Y N Since	Since_	Y N Since	Y N Since	Y N Since	Y N Since
13. Disease of the musculoskeletal system /Orthopedic disorders/Fracture or dislocation of bones or joints/ avascular necrosis of joints or any other disorder related to it?	Since	Y Since	Y N Since	Y N Since	Y N Since	Y N Since
14. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please indicate the following:						
 Hard Liquor (No. of Pegs in 30 ml per week) Beer(Bottles/ml per week) Wine(Glasses/ml per week) Smoking (no. of Sticks per day) Gutka/Pan Masala/Chewing Tobacco(Sachets/Grams per day) 						
15. Any other disease / health adversity / injury/ condition / treatment not mentioned above?	Since	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since
16. Has any of the Proposed to be Insured been hospitalized /recommended to take investigations/medication or has been under any prolonged treatment/ undergone surgery for any illness/injury other than for childbirth/minor injuries?	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since
17. Has any of the Proposed to be Insured have been suffering/suffered from Covid-19 disease?	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since	Y N Since
If yes, confirm if any complications arise due to covid-19						
Note: The Company shall reject Your proposal and refund the premium amo other reason.			, , , ,		, , ,	,
ADDITIONAL INFORMATION (IF YOUR ANSWER INSURED ARE SUFFERING FROM ANY OTHER PRE						
ATTENDING PHYSICIAN'S DETAILS						
Name of Family Physician : (First Name)		(Mid	dle Name)		(Last Nam	e)
Contact Number:	Er	mail:				
DETAILS OF PREVIOUS OR EXISTING HEALTH IN	SURANCE					
Please fill the following details with respect to health insurance proposals a	policies with the	Company or any Insured 2	other insurance c	ompanies Insured 4	Insured 5	Insured 6
Have any of the person(s) to be insured ever filed a claim with their current/ previous insurer? If Yes, please provide details on a separate sheet	N	Insured 2	Insured 3	Insured 4	Insured 5	Y N
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	YN	YN	YN	YN	YN	YN
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?	Y N Since	Y N Since	Since	Since	Since	Since
5.54.4		(DD/MM/YYYY)		(DD/MM/YYYY)		

 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 policome 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 before communication of the risk acceptance by the company. 	
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.	cy will
	d hut
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 any past or present employer concerning anything which affects the physical or mental health of the person to be insured / proposer and seeking information from any Insu 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 settle	rer to
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 or claims settlement and with any Governmental and/or Regulatory authority.	land/
Date : / / / (DD/MM/YYYY) Signature of the Proposer :	_
Place: (On behalf of all the persons to be insured under the Policy)	
PREMIUM PAYMENT INFORMATION	
Payment By: Cash / Cheque / Demand Draft / Card /ECS (NACH)/Reward Points/Wallet/Any other mode (Strike out whichever is not applicable)	
Premium payment mode: Single ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ (☑ Tick whichever is applicable)	
Cheque / Demand Draft No. / Authorization ID :	
Payment Amount (₹):	
Date: 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 Limited"	
Note: Should you choose to pay premium by cash, you are advised to do so only at the nearest Care Health insurance limited branch or any authorized Bank branch, and we insist you to please ask for computerize receipt against the deposited case.	n against
your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.	
NEFT DETAILS (FOR CLAIMS & REFUND PURPOSES)	
Account Number : IFSC Code :	
Bank Name : Bank Branch Name :	
Name of the Account Holder:	
Note: Please submit copy of cancelled cheque along with Proposal Form	
I declare that the information given above is true and correct. I hereby authorize Care Health Insurance Limited to directly credit payout/refund, if any, to the above mentioned account and I shall not hold Care Health Insurance Limited to incorrect/incomplete information. Care Health Insurance Limited reserves right to use any alternative payout option	
cheque/demand draft in spite of providing above information.	1001103
Date : /	
Place: (On behalf of all the persons to be insured under the Policy)	
(Offiberiali of all the persons to be insured under their only)	
(On benan of an trepersons to be insured under the folicy)	
STATUTORY WARNING	
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STATUTORY WARNING Prohibition of Rebates (Under Section 41 of freumance 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 commission payable or any rebate of the persons on the published prospectables of the finance. 2. Any person making default in complying with the provisors of this section shall be fable for a penalty which may extend to ten likih rupees. FOR OFFICE USE ONLY (Intermediary Details) Intermediary Name: Intermediary Name: Intermediary Name: Intermediary Code: Branch code: Care Health Insurance Branch Details: Relationship Manager Name: Branch code: Client ID: Details of 'Point of Sales' Person: (To be filled in if the Policy is sourced through 'Point of Sales' Person) Please furnish at least one of the following details of "Point of Sales" Person: Aadhaar Card No: PAN Card No: PECLARATION FOR AGENTS Intermedial price of the Brokenfelationship Officer do hereby declare that I have all the contents of this Proposal Form induling the nature of the questions contained in this Proposal form to detail or any details out of the Policy is submissions, furnished to be furnished, the Corporate Agent/ Authorized employee of the Brokenfelationship Officer, do hereby declare that I have all the contents of this Proposal Form induling the nature of the questions contained in this Proposal Form to determent, information and response(s) submitted by hin/her in this Proposal Form to yellow the proposal price succepted by the Corporary and and void and all prefer to explicate the the Bell price and and void and all prefer to explicate the the Bell price was all the contents of this Proposal Form to one decisions contained in this Proposal Form one decisions contained that if any statement	xplained d herein er Police
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STATUTORY WARNING Prohibition of Rebates (Under Section 4) of insurance Act 1938) 1. Ne person thail allow or offer to allow either directly, 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 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 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 person to take of the India or 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 person to take of the India or 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 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 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 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 person to be allowed in accordance with the published prospect take or of the India and any rebate of the whole or person or 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 person or take out or the live of the India and Ind	xplained d herein er Police

DECLARATION

ADDENDUM - VERNACULAR DECLARATION	
I, son/daughter of fully explained the contents of the Proposal Form and all other accompanying documents in	resident of declare that I have read out and language to the Proposer which is a language understood by him/her and is imperative for understood by him/her and the replies have been recorded according to the information provided by the Proposer. The replies have also
Date: (DD/MM/YYYY)	Place:
Name of the Declarant:	Signature of the Declarant:
(On behalf of all the Proposed to be Insured under the Policy)	
ANNEXURE – I: OPTIONAL COVERS	
Optional Benefit: Room Rent and ICU Modification: Yes No	
(If Yes, then please mention the option opted: Option I Option :	
Optional Benefit: Sub-Limit on Advance Technology Methods: Yes No	
(If Yes, then please tick mark the options opted: Sublimit I Sublimit	.2
Optional Benefit: Unlimited Automatic Recharge: Yes No	
Optional Benefit: OPD Care Yes No	
(If Yes, then please mention the coverage amount opted	
Optional Benefit: OPD Consultation & Therapy Expenses: Yes No	
(If Yes, then please mention the coverage amount opted	
Optional Benefit: Sub-Limit on Specified Diseases Yes No	
(If Yes, then please tick mark the options opted: Sublimit I Sublimit	
Optional Benefit: Voluntary Co-Payment Option Yes No	
(If Yes, then please mention Co-pay (in %.)	
Optional Benefit: No Claim Bonus Super: Yes No	
Optional Benefit: Additional Sum Insured for Accidental Hospitalization: Yes	No
Optional Benefit: Air Ambulance Cover Yes No	
Optional Benefit: Smart Select: Yes No	
Optional Benefit: Increase in PED Waiting Period: Yes No	
(If Yes, then please mention the waiting period option opted: 2 Years 4 Years	
Optional Benefit: Instant Cover: Yes No	
Optional Benefit: Termination of Automatic Recharge Coverage: Yes No	
Optional Benefit: Modification of No Claim Bonus: Yes No	
Optional Benefit: Disease Management Programs for: Asthma: Yes No	
Diabetes Mellitus: Yes No	
Hypertension: Yes No	
Hyperlipidemia: Yes No	
Optional Benefit: Modification of Pre-hospitalization Medical Expenses	
and Post-hospitalization Medical Expenses: Yes No	
Optional Benefit: Companion Benefit: Yes No	
Optional Benefit: Sub-Limit on Hospitalization related Expenses: Yes No	
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 Cash/Cheque/DD No./Authorization ID from
Mr/MsPlease note that this is or	ly an acknowledgement receipt and does not amount to acceptance of risk or commencement of the Policy. The folicy Start Date. The validity of this receipt is subject to realization of the proposal amount. Acceptance of proposal
Signature of the Representative :	Name of the Representative :
Insurance is a subject matter of solicitation. IRDA1 Registration No. 148	Constitution of the Consti
Note: Should you choose to pay premium by cash, you are advised to do so only at the nea computerize receipt against the deposited cash against your Proposal. Any claim without compu	rest Care Health insurance Limited branch or any authorized Bank branch, and we insist you to please ask for terized receipt against the deposited cash will not be admitted.

Care Health Insurance Limited