Proposal Form

'S'

URN : CHIL / R / TR / 104 / 22-23

Proposal No.:_____

1. 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 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.
6. The proposer's age should above 18 years.

FOR OFFICE USE ONLY

Intermediary Details

Intermediary Code :		Intermediary Name :	
Partner RM Code :		Partner Branch Code :	
Customer Acc No. :			

Care Health Insurance Branch Details

CHIL RM Name :			
Branch Code :		Client ID :	Receipt 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.:

PROPOSER DETAILS

Name : (Mr./Ms./Mrs.)			
	(First Name)	(Middle Name)	(Last Name)
Correspondence Address :			
Locality :		City :	
Pin Code :		State :	
Landmark :			
Permanent Address : If same as above, please tick here ☐			
Locality :		City :	
Pin Code :		State :	
Telephone :		Mobile* :	
Alternate No. :			
Email :			

*The registered mobile number will be enrolled for WhatsApp notifications related to your Care Health Insurance Policy

Date of Birth / Incorporation (in case Proposer is an entity) : D D M M Y Y Y Y Gender : Male ☐ Female ☐ Others ☐

Marital Status : Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated ☐

Mother's Name :			
PAN Number :		Nationality :	
Form 60 (only in case the customer does not have PAN no.) :	☐ Yes ☐ No	Aadhaar Number(last 4 digits):	X X X X X X X X

(By signing the Proposal form I give my consent for using my Aadhaar No. for Authentication of my Aadhaar Details)

Please share the following for authentication purpose:

Proof of Identity (POI) (☑ Tick whichever is applicable)

PAN ☐ Aadhaar ☐ Passport ☐ Driving License ☐ Voter ID Card ☐

Letter from a recognized public authority or public servant verifying the identity and residence of the Proposer ☐

Proof of Address (POA) (☑ Tick whichever is applicable)

Electricity bill (not older than 3 months) ☐ Aadhaar ☐ Passport ☐ 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 an e-Insurance Account (eIA) of an Insurance Repository? Yes ☐ No ☐

If you have an eIA, please provide following details:

I) Name of Insurance Repository :	
ii) eIA No :	
iii) Name as appearing in eIA :	

If you do not have an eIA, would you like to open an account? Yes ☐ No ☐

If Yes, choose any one Insurance Repository:

☐ NDML – NSDL Data Management Limited	☐ CAMSRep- CAMS Repository Services Limited
☐ Karvy Insurance Repository Limited	☐ CIRL-Central Insurance Repository Limited (CDSL)

Help us preserve the environment by opting to receive policy related information in soft copy/via email only : Yes ☐ No ☐

POLICY DETAILS

Policy Period Start Date :	D D M M Y Y Y Y	Policy Duration (in months) :		
Geographical Scope	☐ Worldwide excluding India	☐ Worldwide (excluding US, Canada and India)		
Plan Opted :	☐ Start	☐ Plus	☐ Super	☐ Ultra
Purpose of travel	☐ Study	☐ Profession or semi Professional sport	☐ Aviation training	
Optional Cover 1 : Self-inflicted injury	☐ Yes	☐ No		
Optional Cover 2 : HIV / AIDS Cover	☐ Yes	☐ No		
Optional Cover 3 : Adventure Sports Injury	☐ Yes	☐ No		
Optional Cover 4 : Vision Care	☐ Yes	☐ No		
If Yes, then the Optional Cover opted is due to University requirement?	☐ Yes	☐ No		
Optional Cover 5 : Home Care	☐ Yes	☐ No		
Optional Cover 6 : Family cover	☐ Yes	☐ No		
If Yes, then the Sum Insured opted ($)		wait period opted	months	the co-payment opted %
Optional Cover 7 : Maternity Cover	☐ Yes	☐ No		
If Yes, then the Sum Insured opted ($)		wait period opted	months	the co-payment opted %
Optional Cover 8 : Maternity & New Born Cover	☐ Yes	☐ No		
If Yes, then the Sum Insured opted ($)		wait period opted	months	the co-payment opted %
Optional Cover 9 : Co-payment Option	☐ Yes	☐ No	(If Yes, then the Co-payment opted is)	%
Optional Cover 10 : Deductible Option	☐ Yes	☐ No	(If Yes, then the Deductible opted ($)	
Optional Cover 11 : Complete Pre-Existing Disease Cover in Life Threatening Medical Condition	☐ Yes	☐ No		

Note : The Proposed to be Insured may opt for Optional Cover 1, Optional Cover 2, Optional Cover 7, Optional Cover 8 & Optional Cover 11 only if it is a University requirement.

NOMINEE DETAILS

Nominee Name	Date of Birth (DD/MM/YYYY)	Relationship with Proposer

*If the Nominee is of Age 18 years or less, Name of Appointee and Relationship with Minor:

Appointee Name	Date of Birth (DD/MM/YYYY)	Relationship with Minor

In event of the death of the Proposer any payment due under the policy shall become payable to the nominee proposed in this form. The receipt of the proceeds by the Nominee would be sufficient discharge to the company. Nominee for all the other person(s) proposed to be insured shall be the proposer himself.

DETAILS OF PERSONS TO BE INSURED

Insured 1 ' Name : Mr./Ms./Mrs.				
Passport No.			Date of Birth	D D M M Y Y Y Y
Gender	Male ☐ Female ☐ Others ☐	Aadhaar/PAN No.(Optional)		If PEP* : ☐ Yes ☐ No
Relationship with Proposer :		Relationship with Student :		
Sum Insured of Medical Expenses (in US $)	☐ 10,00,000	☐ 5,00,000	☐ 3,00,000	☐ 1,00,000 ☐ 50,000
Do you have ABHA No.	Yes ☐ No ☐	If Yes, please provide ABHA Number (Optional)		
Insured 2 : Name : Mr./Ms./Mrs.				
Passport No.			Date of Birth	D D M M Y Y Y Y
Gender	Male ☐ Female ☐ Others ☐	Aadhaar/PAN No.(Optional)		If PEP* : ☐ Yes ☐ No
Relationship with Proposer :		Relationship with Student :		
Sum Insured of Medical Expenses (in US $)	☐ 10,00,000	☐ 5,00,000	☐ 3,00,000	☐ 1,00,000 ☐ 50,000
Do you have ABHA No.	Yes ☐ No ☐	If Yes, please provide ABHA Number (Optional)		
Insured 3 : Name : Mr./Ms./Mrs.				
Passport No.			Date of Birth	D D M M Y Y Y Y
Gender	Male ☐ Female ☐ Others ☐	Aadhaar/PAN No.(Optional)		If PEP* : ☐ Yes ☐ No
Relationship with Proposer :		Relationship with Student :		
Sum Insured of Medical Expenses (in US $)	☐ 10,00,000	☐ 5,00,000	☐ 3,00,000	☐ 1,00,000 ☐ 50,000
Do you have ABHA No.	Yes ☐ No ☐	If Yes, please provide ABHA Number (Optional)		

Insured 4 : Name : Mr./Ms./Mrs.			
Passport No.		Date of Birth	D D M M Y Y Y Y
Gender Male ☐ Female ☐ Others ☐	Aadhaar/PAN No.(Optional)	If PEP* :	☐ Yes ☐ No
Relationship with Proposer :		Relationship with Student :	
Sum Insured of Medical Expenses (in US $)	☐ 10,00,000 ☐ 5,00,000 ☐ 3,00,000 ☐ 1,00,000 ☐ 50,000		
Do you have ABHA No. Yes ☐ No ☐	If Yes, please provide ABHA Number (Optional)		

Pre-existing disease (Please tick)	Month & Year when such Pre-existing Disease was first detected			
	Insured 1	Insured 2	Insured 3	Insured 4
☐ Cancer/ Tumor	M M Y Y	M M Y Y	M M Y Y	M M Y Y
☐ Coronary Artery Heart disease	M M Y Y	M M Y Y	M M Y Y	M M Y Y
☐ Insulin Dependent Diabetes	M M Y Y	M M Y Y	M M Y Y	M M Y Y
☐ Paralysis/ Stroke	M M Y Y	M M Y Y	M M Y Y	M M Y Y
☐ Congenital Disease	M M Y Y	M M Y Y	M M Y Y	M M Y Y
☐ HIV/ AIDS/ STD	M M Y Y	M M Y Y	M M Y Y	M M Y Y
☐ Liver Disease	M M Y Y	M M Y Y	M M Y Y	M M Y Y
☐ Kidney Disease	M M Y Y	M M Y Y	M M Y Y	M M Y Y
☐ Thalassemia	M M Y Y	M M Y Y	M M Y Y	M M Y Y
☐ Other (Please Specify)#				
	M M Y Y	M M Y Y	M M Y Y	M M Y Y

#In case the above named person(s) is/ are suffering from an illness/ disease other than those referred above or have been diagnosed/ hospitalized or taken any treatment / medication for any illness/ disease in the past, then please provide complete details.

*Have you ever been entrusted with prominent public functions, forexample, 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.

ADDITIONAL INFORMATION

EDUCATIONAL INSTITUTE DETAILS

Name of Educational Institute	Educational Course Details	Educational Institute Address	Country

Whether the Optional Cover(s) opted is due to University requirement? ☐ Y ☐ N

SPONSOR'S DETAILS

Sponsor's Name	Date of Birth (DD/MM/YYYY)	Relationship with Insured	Address

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 insured / 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.

Date : __ / __ / ____ (DD/MM/YYYY)   Signature of the Proposer :____________________

Place :   (On behalf of all the persons to be insured under the Policy)

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 responsible for non-credit/non-payment of payout or refund, if any, due to any reason including but not limited to incorrect/incomplete information. Care Health Insurance Limited reserves right to use any alternative payout option such as cheque/demand draft in spite of providing above information.

Date : / / (DD/MM/YYYY)

Signature of the Proposer :_____

Place :

(On behalf of all the persons to be insured under the Policy)

PAYMENT DETAILS

Mode of payment Cash / Cheque / Demand Draft / Any other mode (Strike out whichever is not applicable) :			
Cheque / Demand Draft No. / Instrument No / Authorization ID :			
Payment Amount (₹) :			
Instrument Date :		Bank Name :	

In case of payment through Cheque / Demand Draft, it should be drawn in favor 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 cash against your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.

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.

DECLARATION FOR AGENTS

I _____ (Full Name) in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/ Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form basis of the Contract of Insurance between the Company and the Proposer, if this proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable as per Policy Terms and Conditions and furthermore, if there has been a non-disclosure of any material fact, the policy issued to his/her favor pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the Company.

License No. (Advisor/Corporate Agent/Broker/Relationship Officer):

Date : / / (DD/MM/YYYY)

Signature : _____

SP Name : _____

SP Code :

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 Cash/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 the Policy. The Company is not liable for any claim between the time that the proposal amount is received and Policy Start Date. The validity of this receipt is subject to realization of the proposal amount. Acceptance of proposal and issuance of the Policy shall be subject to receipt of the completed Proposal Form, premium payment, medical reports (wherever applicable) and underwriting decision of the Company.

Proposal No.: _____

Signature of the Representative : _____

Name of the Representative : _____

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

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 cash against your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.