Proposal Form

'S'

URN : CHIL / R / TR / 111 / 23-24

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.
7. The proposed policyholder will be referred to in this Proposal Form as "Proposer", "You" or "Your".

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 ☐

NOMINEE DETAILS

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

*If the Nominee's age is less than 18 years, 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.

POLICY DETAILS

Plan:				
Policy Period Start Date: D D M M Y Y Y Y	Policy Period End Date: D D M M Y Y Y Y	Policy Duration (total in days):		
Purpose of Travel:				
Optional Cover: Daily Allowance:	☐ Yes	☐ No		
Optional Cover: Loss of Checked-in Baggage:	☐ Yes	☐ No	☐ Sum Insured USD $ 1000,	☐ USD $ 2000
Optional Cover: Delay of Checked-in Baggage:	☐ Yes	☐ No		
Optional Cover: Loss of Passport:	☐ Yes	☐ No	☐ Sum Insured USD $ 150,	☐ USD $ 200
Optional Cover: Loss of International driving license:	☐ Yes	☐ No	☐ Sum Insured USD $ 100	☐ USD $ 150
Optional Cover: Personal Liability:	☐ Yes	☐ No		
Optional Cover: Study interruption:	☐ Yes	☐ No	☐ Sum Insured USD $ 10,000	☐ USD $ 15,000
Optional Cover: Sponsor Protection:	☐ Yes	☐ No		
Optional Cover: Bail Bond:	☐ Yes	☐ No		
Optional Cover: University Insolvency:	☐ Yes	☐ No		
Optional Cover: Trip Delay:	☐ Yes	☐ No		
Optional Cover: Loss of Laptop / Tablet:	☐ Yes	☐ No		
Optional Cover: Adventure Sports Injury:	☐ Yes	☐ No	☐ Sum Insured USD $ 50,000	☐ USD $ 1,00,000
		☐ USD $ 300,000	☐ USD $ 500,000	☐ USD $ 1000,000
Optional Cover: Family cover:	☐ Yes	☐ No		
Optional Cover: Health Screening /Preventive Care	☐ Yes	☐ No	☐ USD $ 500 ☐ USD $ 1,000	☐ USD $ 2,000 ☐ USD $ 5,000

Optional Cover: Deductible Options

S.No.	USA & Canada (In-Network)	USA & Canada (Out-of-Network)	Outside USA & Canada
Option 1 ☐	USD 100	USD 250	USD 100
Option 2 ☐	USD 400	USD 400	USD 400
Option 3 ☐	USD 500	USD 750	USD 500

DETAILS OF PERSONS TO BE INSURED

Self (Student) : Name : Mr./Ms./Mrs.			
Date of Birth: D D M M Y Y Y Y	Gender:	Male ☐ Female ☐ Others ☐	
Relationship with Proposer:	Marital Status:		Passport Number:
Aadhaar Number /PAN(optional):		Nominee (Relationship with Insured):	
City of Residence:			
Do you have ABHA No. ☐ Yes ☐ No	If Yes, please provide ABHA Number (Optional)		
Height (in centimeters):	Weight (in kilograms)		

Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations or important political party officials ☐ Yes ☐ No

Spouse : Name : Mr./Ms./Mrs.			
Date of Birth: D D M M Y Y Y Y	Gender:	Male ☐ Female ☐ Others ☐	
Relationship with Proposer:	Marital Status:		Passport Number:
Aadhaar Number /PAN(optional):		Nominee (Relationship with Insured):	
City of Residence:			
Do you have ABHA No. ☐ Yes ☐ No	If Yes, please provide ABHA Number (Optional)		
Height (in centimeters):	Weight (in kilograms)		

Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations or important political party officials ☐ Yes ☐ No

Dependent Child : Name : Mr./Ms./Mrs.			
Date of Birth: D D M M Y Y Y Y	Gender: Male ☐	Female ☐	Others ☐
Relationship with Proposer:	Marital Status:		Passport Number:
Aadhaar Number /PAN(optional):		Nominee (Relationship with Insured):	
City of Residence:			
Do you have ABHA No. ☐ Yes ☐ No	If Yes, please provide ABHA Number (Optional)		
Height (in centimeters):	Weight (in kilograms)		

Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations or important political party officials ☐ Yes ☐ No

Dependent Child : Name : Mr./Ms./Mrs.			
Date of Birth: D D M M Y Y Y Y	Gender: Male ☐	Female ☐	Others ☐
Relationship with Proposer:	Marital Status:		Passport Number:
Aadhaar Number/ PAN(optional):		Nominee (Relationship with Insured):	
City of Residence:			
Do you have ABHA No. ☐ Yes ☐ No	If Yes, please provide ABHA Number (Optional)		
Height (in centimeters):	Weight (in kilograms)		

Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations or important political party officials ☐ Yes ☐ No

MEDICAL / LIFESTYLE RELATED INFORMATION

Particulars	Self (Student)	Spouse	Dependent Child	Dependent Child
Has any proposed insured currently or in past Diagnosed/Suffered/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	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
2. Any heart disease or disorder, chest pain or discomfort, irregular heartbeats, palpitations or heart murmur	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
3. Hypertension / High Blood Pressure(BP)/ High Cholesterol/Any other Lipid disorders	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
4. Asthma / Tuberculosis (TB) / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease?	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
5. Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pituitary tumor/ disease or any other disorder of Endocrine system?	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
7. Motor Neuron Disease/ Muscular dystrophies/ Myasthenia Gravis/ Demyelinating disease or any other disease of Neuromuscular system (muscles and/or nervous system)	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
8. Stroke/ Paralysis/ Transient Ischemic Attack/ Multiple Sclerosis/ Epilepsy/ Mental-Psychiatric illness/ Parkinsonism/ Alzheimer's/ Depression / Dementia or any other disease of Brain and Nervous System?	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No 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?	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs?	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
11. HIV/SLE/ Rheumatoid Arthiritis / Scleroderma / Sarcoidosis/ Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin.	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
12. Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses)?	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
13. Disease of the musculoskeletal system /Orthopedic disorders/Degeneration , Fracture or dislocation of bones or joints/ avascular necrosis of joints or any other disorder related to it?	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
14. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please indicate the following:	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
- 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?	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No 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?	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______
17. Has any of the Proposed to be Insured have been suffering/suffered from Covid-19 disease? If yes, confirm if any complications arise due to covid-19	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______	☐ Yes ☐ No Since_______

Note: The Company shall reject Your proposal and refund the premium amount (after deducting cost of medical tests, if any) in case of incompleteness or any discrepancy highlighted or any other reason.

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 EXISITNG DISEASE WHICH IS NOT MENTIONED IN THE ABOVE LIST)

_____

_____

_____

_____

_____

ADDITIONAL INFORMATION

Educational Institute Details:

Name of Educational Institute:					
Educational Course Details:					
Educational Institute Address:				Country:	
Semester System: ☐ Yes ☐ No,	Annual: ☐ Yes ☐ No	Any other System, please specify : _____			
Course Fee Per Semester (if applicable): _____, Total Fee: _____		Course Session _____			
Course Duration: From ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)	To ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)	Total Course Duration (in Months):			

Sponsor's Details

Sponsor's Name	Date of Birth	Relationship with Insured	Address

PAYMENT DETAILS

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)
Note:(Monthly/Quarterly/Half-yearly Installment option available only in case of Policy Duration of 1 Year/2 Year/3 Years.)					
Premium Amount (INR):			Cheque / Demand Draft No. / Authorization ID:		
Date:		Payment Amount (INR):			
Bank Name:					

For Premium computation, Zone shall be considered as per Correspondence address

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

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

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.

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)

Place : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Signature of the Proposer :_____

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

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.

PROPOSER'S 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.

f. I authorize the company to use 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.

Date: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Signature of the Proposer: _____

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

Place: _____

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: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ADDENDUM – VERNACULAR DECLARATION

I _____, son / daughter of _____, resident of _____ declare that I have read out and fully explained the contents of the proposal form and all other accompanying documents in _____ language imperative to availing the insurance from the Company to the proposer in the language understood by him. The contents and import of the proposal have been fully understood by him and the replies have been recorded according to the information provided by the proposer. The replies have also been read out to, fully understood and confirmed by the proposer.

Date: ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Name of the Declarant: _____

Place: _____

Signature of the Declarant: _____

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

Acknowledgement for Proposal

Please retain this counterfoil for your records

(On behalf of Care Health Insurance Limited)

We acknowledge the receipt of payment of ₹_____ vide 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.