

ultimate carē

Proposal Form



URN: CHIL / R / HE / 121 / 24-25 Proposal No.:_

- To be filled in by the Proposer in CAPITAL LETTERS only.
- To be lined in by the Proposer in CAPINAL 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. The proposed policyholder will be referred to in this Proposal Form as "Proposer", "You" or "Your".

FOR OFFICE USE ONLY																							
Intermediary Details																							
Intermediary Code :						Inte	ermedia	ıry N	lame	e:													
Intermediary RM Code :						Bra	anch Co	de :															
Customer Acc No.:																							
Care Health Insurance Branch Details																							
CHI RM Name :																							
Branch Code :					Client I	D:								Re	ceip	t ID	:						
Details of 'Point of Sales' Person : (To be filled	d in if	the P	olicy is	sourced	through	'Poir	nt of Sal	es' Pe	erso	n)													
Please furnish at least one of the following details of	"Poin	t of S	ales'' P	erson:																			
Aadhaar Card No.:									PA	N Card	l No.:												
PROPOSER DETAILS																							
Name : (Mr./Ms./Mrs.)		(F: N							4° 1 II									0 1					
Correspondence Address :		(First N	vame)					(1)	rlidal	e Name)							((Last	Nam	e)			
Correspondence Address .													-										
Locality:	-								Cit	7/ 1			+								+		
Pin Code :						Sta	te ·		Cit	-y ·			+										
Landmark:	-					Jia							+								+		
Permanent Address :																							
If same as above, please tick here																							
Locality:									Cit	ty:													
Pin Code : State :																							
Telephone : Mobile* :																							
Alternate No. :																							
Email:																							
*The registered mobile number will be enrolled for	What	sApp	notific	ations re	lated to	your	Care H	lealth	n Ins	urance f	Policy	O											
Date of Birth / Incorporation (in case Proposer is an	entit	y) : [DD	MM	I Y Y	Y	Y		Ge	ender :	Male	9			Fem	nale			0	thers			
Marital Status : Single	Mar	ried			Di	vorce	ed			Wido	ow(er) [Se	para	ated							
Mother's Name :			T																				
PAN Number:							Natio	nality	' :														
Form 60 (only in case the customer does not have PAN no.) :		Yes			No		Aadha	ar Ni	umb	er (last	4 dig	its):	X	X	X	X	X	X	X	X			
CWC.							(By signing th	e Proposa	al form I	give my consen	t for using I	ny Aadhaai	No. for A	Authentica	ation of r	my Aadhi	aar Deta	ils)					
CKYC:																							
Please share the following for authentication purpose	:																						
Proof of Identity (POI) $$ ($$ Tick whichever is applicable	le)																						
PAN Aadhaar Passport	Dri	iving L	icense		/oterID	Card																	
Letter from a recognized public authority or public serv	vant v	erifyin	ig the ic	dentity an	d resider	nce o	fthe Pro	pose	er														
Proof of Address (POA) (✓ Tick whichever is applica	ıble)																						
Electricity bill (not older than 3 months)	Aad	dhaar		Pa	ssport			Ra	ation	Card			ı	Drivi	ng Li	icens	se						
Telephone Bill (not older than 3 months)	Bar	nk Acc	ount St	tatement	t (not old	erth	an 3 mo	nths)															
Letter from a recognized public authority or public serv	vant v	erifyin	gthe ic	dentity an	d resider	nce o	fthe Pro	pose	er [: :

Would you like to	A, please pr	rovide fol	llowi			thro	ughan	e-Ir	nsurar	ice A	coun	t (e	elA) of ar	n Insu	ranc	е Керо	sitor	ry?	Yes	5								No	o [
I) Name of Insu	urance Re _l	pository:	:															_										_		_	_		
ii) elANo:																																	
iii) Name as app	earing in e	elA:																															
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□ NDML-N	NSDL Dat	a Manage	emer	nt Limit	ted										C.	AMSRe	p-C	:AM	IS Insi	uran	ce Re	epos	itory	/&Se	ervic	es							
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Bank Name	2																																
Name of th	ie Accoun	t Holder																															
Appointee De	etails (Only	where the	e No	minee	age is	less	than I	8 yea	ars)																								
Appointed	e Name		Age	e			Mobil	e N	Ο.							Ema	il ID	1								Re	lation	ship	with	h Mir	nor		
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In event of the d Beneficiary wou In case you want	ld be suffi	cient disc	harg	ge to th	ne Co	omp	any. Tł	ne N	Vomir	ee fo	r all t	ne d	other pe	erson	(s) p	ropose	d to	be	insun	ed sł	nall b	e th	e Pro	opos	er hii	mse	lf.	eeds	s by t	the N	Vom	inee/	
DETAILS C	F THE	PROP	09	SED.	ТО	BE	INS	UF	RED	INC	LUI	DII	NG PI	ROF	0	SER																	
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Care Health Insu	rance Lim	ited																															

Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019 Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road, Sector-43, Gurugram-122009 (Haryana) Website: www.careinsurance.com CIN: U66000DL2007PLC161503 UIN:CHIHLIP25044V012425 IRDAI Registration No. - 148

Insured 4 : Na	1	Ms./Mrs.																			
Height	cms	Marital St	atus				Date	e of Birth	DD	MM	I Y I	Υ	Y	Annua	l Incon	ne (In Lac	:s) :	₹			
Weight	kg	Gender	Male		Female		Others	Ш	ļ A	Aadhaar □			ptional)							
Nominee (Relations				_		with Prop				City	of Resid	ence :					If P	EP*:	Yes		No 📙
Do you have AB		Yes	No 🗌	lf`	Yes, please	provide /	ABHA N	lumber (C	Optional)												
Insured 5 : Na	1	1								N 4 N .		/ \/					_		-		
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MEDICAL /	LIFES	TYLE RI	ELATE	D IN	FORM.	ATION															
Particulars								ıred I	Insu	red 2	Ins	ured	3	Ins	ured	4	Insu	red !	5	Ins	ured 6
Does any p Diagnosed/Suffe conditions: If ye section below:	ered/Treat	ed/Taken N	Medicatio	n for	any of the	e followin	g														
L Concentum		n sust					Y	N	Y	N	Y		N	Y	N	1	Y	N		Y	N
1. Cancer, tumo	or, polyp o	rcyst					Since	3	Since.		Sin	ce		Sinc	e		Since		_	Sinc	e
2 Any heart o	disease or	disorder	chest na	in or	discomfor	t irregula	rY	N	Y	N	Y	1 [N	Y		1	Y			Y	N
Any heart disease or disorder, chest pain or discomfort, irregular heartbeats, palpatations or heart murmur					Since	e	Since		Sin			Since		_	Since	=	_	Sinc	.e		
							Y	N	Y	N	Y	1 [N	Y		J	Y		П	Y	N
3. Hypertensio	on / High Bl	ood Pressu	ıre(BP)/ H	High Ch	olestrol		Since		Since		Sin			Sinc			Since			Sinc	
4. Asthma / Tu	ıberculosi	s (TB) / C	OPD/ Ple	eural e	ffusion / F	Bronchitis	_	N	Y	N	Y		N	Y		_	Y			Y	
Emphysema Respiratory	or any o								Since.		Sin			Sinc			Since			Sinc	
5. Thyroid dise disease / Pitu system?								N e	Y Since	N	Sin		N	Sinc	e	1	Since		1	Sinc	e
6. Diabetes M medication	lellitus /	High Bloo	d Sugar	/ Dial	oetes on	Insulin o	r Y Since	N	Y Since	Ν	Y Sin		N	Sinc	e.	1	Y			Sinc	e N
7. Motor Neur any other dis	ron Disea sease of N	se/ Musculi Jeuromusci	ar dystro ular syste	phies/ m (mu	Myasthnia scles and/	a Gravis o	r Y	N	Y	N	Y		N	Υ		1	Υ	N		Υ	N
system)							Since	<u></u>	Since.		Sin	ce	_	Sinc	e	_	Since		_	Sinc	e
8. Stroke/ Para Epilepsy/ M	alysis/ Tr 1ental-Psy	ansient Isc rchiatric ill	chemic <i>F</i> Iness/ Pa	Attack/ arkinsc	Multiple nism/ Al	Sclerosis zeihmer's	5/ Y	N	Y	N	Y		N	Υ	1	1	Υ	Ν	1	Υ	N
Depression/	Dementia	or any othe	r disease o	of Brain	and Nervo	ous System	? Since		Since.		Sin	ce	_	Sinc	e	_	Since		-	Sinc	e
9. Cirrhosis / H Crohn's dise								N	Y	N	Y		N	Y	N		Y			Y	N
Mouth, Esop	ohagus, Liv	ver, Gall bla						e	Since.		Sin			Sinc	e	_	Since		_	Sinc	e
other part of 10. Kidney Stor			Dialveie/	Chro	nic Kidne	v Disease	e/ Y	N		N			N	Y						Y	N
Prostate Dis	sease on a	any other	disease c	of Kidn	ey, Ürinar	y Tract o	Since		Y Since		Sin		1 1	Sinc		<u>ا</u> ا	Since			Sinc	
II. HIV/SLE/ A		Sclerodom) / P.o.	riacic/	hlaedina	or clottin	_				_					_	_				
disorders or								N	Y Since	N	Sin		N	Sinc		<u>ا</u> ا	Since		4	Sinc	N
Skin.											_	1 -	_			_			_		
12. Disease or di problems coi					cept any s	ight relate		N	Cinas	N	Cim		N	Y Cin a			Cina	L		Y Cin a	N
		· · ·					Since		Since.		Sin		_	Sinc		_	Since		-	Sinc	
13. Disease o disorders/De avascular nec	egeneratio	on , Fractur	e or disl	ocatior	of bones	or joints	/	e	Since.	N	Sin		N	Sinc	e		Since	2		Sinc	re
14. Smoke, cons recreational								N e	Y Since	N	Sin] [ce	N	Sinc	e	_	Since	<u> </u>	_	Sinc	ne
- Hard Liquo - Beer (Bottle - Wine (Glas - Smoking (n - Gutka/Pan	les/ml per sses/ml pe no. of Stick	week) rweek) sperday)		ŕ	rams per d	tav)							_ _ _			_ _ _			- - -		

15. Any other disease / health adversity / injury/ condition / treatment not mentioned above?	Y N Since	Y N Since	Y N	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	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? If yes, confirm if any complications arise due to covid-19	Y N Since	Y N Since	Y N Since	Since	Y N Since	Y N Since
Note: The Company shall reject Your proposal and refund the premium amo	unt (after deductir	g cost of medical t	ests, if any) in case	of incompleten	ess or any discrepand	cy highlighted or any
ADDITIONAL INFORMATION (IF YOUR ANSWER INSURED ARE SUFFERING FROM ANY OTHER PRI	IS 'YES' TO A	ANY OF THE	ABOVE QU	ESTIONS (OR THE PROPOSED IN THE AI	OSED TO BE BOVE LIST)
DETAILS OF PREVIOUS OR EXISTING HEALTH IN	ISURANCE					
Please fill the following details with respect to health insurance proposals.		Company or any o	other insurance co	ompanies		
Details	Insured I	Insured 2	Insured 3	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	Y	Y	YN	YN	YN	Y
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
	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	Since	Since	Since	Since	Since	Since
break?	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY	(DD/MM/YYYY)	(DD/MM/YYYY)
ATTENDING PHYSICIAN'S DETAILS						
Name of Family Physician :						
TName of Family Physician .						
(First Name)		(Mic	dle Name)		(Last Nar	ne)
(First Name) Contact Number:	E	(Mic	dle Name)		(Last Nar	me)
Contact Number :	E	`	dle Name)		(Last Nar	me)
` /	o be insured, that sse on behalf of the the insurance poli	the above statemese other persons.	ents, answers and a	inderwriting po	given by me are true	and complete in all d that the policy will
Contact Number: DECLARATION a. I hereby declare, on my behalf and on behalf of all persons proposed t respects to the best of my knowledge and that I am authorized to propose to Lunderstand that the information provided by me will form the basis of 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 before communication of the risk acceptance by the company. d. I declare that I consent to the company seeking medical information from any past or present employer concerning anything which affects the powhom an application for insurance on the person to be insured e. I authorize the company to share information pertaining to my proposa	o be insured, that see on behalf of the the insurance police occupation or geomany doctor or hobysical or mental language.	the above statemese other persons. cy, is subject to the eneral health of the persone open made for the ical records of the	Board approved use life to be insured not be insured per purpose of ur nsured/Proposer	Inderwriting po I / proposer after ttended on the proposer and s iderwriting the	given by me are true licy of the insurer and er the proposal has be person to be insured eeking information for proposal and for pose of underwritin	and complete in all d that the policy will been submitted but by proposer or from from any Insurer to a claim settlement.
a. I hereby declare, on my behalf and on behalf of all persons proposed to respects to the best of my knowledge and that I am authorized to proposed to the person only after full payment of the premium chargeable. b. I understand that the information provided by me will form the basis of 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 before communication of the risk acceptance by the company. d. I declare that I consent to the company seeking medical information from any past or present employer concerning anything which affects the pushom an application for insurance on the person to be insured	o be insured, that see on behalf of the the insurance police occupation or geomany doctor or hobysical or mental language.	the above statemes se other persons. cy, is subject to the eneral health of the cospital who / which ealth of the person made for the ical records of the eeking and/or shari	Board approved use life to be insured in at any time has aron to be insured / e purpose of ur nsured/Proposering of my medical company to the purpose of the	I/ proposer after ttended on the proposer and siderwriting the for the sole pur lata through AB	given by me are true licy of the insurer and er the proposal has be person to be insured eeking information for proposal and for pose of underwritin	and complete in all d that the policy will been submitted but by proposer or from from any Insurer to claim settlement. gthe proposal and /
Contact Number: DECLARATION a. I hereby declare, on my behalf and on behalf of all persons proposed to respects to the best of my knowledge and that I am authorized to proposed. I understand that the information provided by me will form the basis of 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 before communication of the risk acceptance by the company. d. I declare that I consent to the company seeking medical information from any past or present employer concerning anything which affects the purchased of the person to be insured. e. I authorize the company to share information pertaining to my proposa or claims settlement and with any Governmental and / or Regulatory au	o be insured, that see on behalf of the the insurance police occupation or geomany doctor or hobysical or mental language.	the above statemese other persons. cy, is subject to the eneral health of the persons even made for the ical records of the eeking and/or shari	Board approved use life to be insured in at any time has aron to be insured / e purpose of ur nsured/Proposering of my medical company to the purpose of the	Inderwriting po I / proposer after ttended on the proposer and s inderwriting the for the sole pur lata through AB thorized Repre	given by me are true licy of the insurer and er the proposal has be person to be insured eeking information for the proposal and / or pose of underwritin HA.	and complete in all d that the policy will been submitted but by proposer or from from any Insurer to claim settlement. gthe proposal and /
Contact Number: DECLARATION a. I hereby declare, on my behalf and on behalf of all persons proposed t respects to the best of my knowledge and that I am authorized to propose to 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 before communication of the risk acceptance by the company. d. I declare that I consent to the company seeking medical information from any past or present employer concerning anything which affects the powhom an application for insurance on the person to be insured e. I authorize the company to share information pertaining to my proposa or claims settlement and with any Governmental and / or Regulatory automates.	o be insured, that see on behalf of the the insurance police occupation or geomany doctor or hobysical or mental language.	the above statemes se other persons. cy, is subject to the eneral health of the cospital who / which ealth of the person made for the ical records of the eeking and/or shari	Board approved use life to be insured in at any time has aron to be insured / e purpose of ur nsured/Proposerng of my medical one of Proposer/Auf of all the persons to	Inderwriting po I / proposer after ttended on the proposer and sonderwriting the for the sole pure lata through AB thorized Represolations and the sole pure late through AB	given by me are true licy of the insurer and er the proposal has be person to be insured eeking information for the proposal and / or pose of underwritin HA.	and complete in all d that the policy will been submitted but l/ proposer or from from any Insurer to claim settlement. g the proposal and /
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all the contents of this Proposel Form, including the nature of the questions contained in this Proposel Form to the Proposer including statement(s), information and response(s) submitted by himmer in this Proposel Form to questions contained or any details sugget herein will from basis of the Contract of Insurance between the Company and the Proposer (if this proposal is according for issuance of the Policy I have further explained that if any statement(s) (information/response(s) is dire contained in this Proposal Form including addendum(s), afficiants, statements, submissions, furnished to be furnished, the Company shall have the right to vary the benefits which may be payable as per Terms and Conclines and furthermore, if there has been and indicators of any material fact, the policy issued to his/her flavor pursuant to this Proposal Formany shall under the Policy inferieted to the Company; the Company as null and void and all premiums paid under the Policy inferieted to the Company; the Company as null and void and all premiums paid under the Policy inferieted to the Company; the Company as null and void and all premiums paid under the Policy inferieted to the Company; as null and void and all premiums paid under the Policy inferieted to the Company; and the Company as null and void and all premiums paid under the Policy inferieted to the Company; and the Company as null and void and all premiums paid under the Policy inferiete to the Company; and the Company as null and void and all premiums paid under the Policy inferiete to the Company; and the Company as null and void and all premiums paid under the Policy inferiete to the Company; and the Company as null and void and all premiums paid under the Policy inferiete to the Company; and the Company as null and void and all premiums paid under the Policy inferiete to the Company; and the Company as null and void and all premiums paid under the Policy inferiete to the Company; and the Company as null and void and all premiums paid under the Policy inferiete t	DECLARATION FOR AGENTS									
Date: / / / / / / / / /	all the contents of this Proposal Form, including the nature of the questions or any details sought herein will form basis of the Contract of Insurstatement(s)/information/response(s) is/are contained in this Proposal Form Terms and Conditions and furthermore, if there has been a non-disclosure forfeited to the Company.	contained in this Proposal Form to the Proposer includi ance between the Company and the Proposer, if the n/including addendum(s), affidavits, statements, submiss	ng statement(s), info nis proposal is accep ions, furnished/to be	ormation and response oted by the Compar of furnished, the Compar	e(s) submitted b ny for issuance any shall have th	y him/her in th of the Policy e right to vary	nis Proposa v. I have fu v the benefi	ıl Form to qu urther expli its which ma	uestions co ained that ay be payab	if any untrue le as per Policy
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Applicable where the Proposer is not able to read/write/ has signed in vernacular language or is suffering from a disability due to which writing is restricted.										
Applicable where the Proposer is not able to read/write/ has signed in vernacular language or is suffering from a disability due to which writing is restricted.				of Code.						
Optional Benefit: Pre-Post Hospitalization Expenses Modification: Yes No (If Yes, then please select) Pre hospitalization (No. of days) Post hospitalization (No. of days) 30 60	him/her and the replies have been recorded according to the information properties. Place	ovided by the Proposer. The replies have also been read	out to, fully understo	ood and confirmed by t	he Proposer.				·	uňdeiřstood by
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Optional Benefit: Infinity Bonus: Yes No Optional Benefit: Unlimited Automatic Recharge Booster: Yes No Optional Benefit: Premium Payback: Yes No Optional Benefit: Unlimited Care: Yes No Optional Benefit: Unlimited E-Consultations: Yes No Optional Benefit: Cover Pause: Yes No Optional Benefit: Grace Period cover: Yes No Optional Benefit: Tenure Multiplier: Yes No Optional Benefit: Instant Cover: Yes No Optional Benefit: Instant Cover: Yes No Optional Benefit: Instant Cover: Yes No Optional Benefit: Inflation shield: Yes No Optional Benefit: Be-Fit Plus Benefit: Yes No Optional Benefit: Concierge/ Geriatric Care: Yes No Optional Benefit: Maternity Cover: Yes No Optional Benefit: Maternity Cover: Yes No Waiting PeriodMonths)			Optional Benefit: Annual Health checkup: Optional Benefit: Smoking & Alcohol Rehabilitation: Optional Benefit: Durable Medical Equipment: (If Yes, then please mention coverage amount) ; Deductible: Optional Benefit: Surrogacy Care: (If Yes, then please mention coverage amount) Optional Benefit: Oocyte Care: (If Yes, then please mention coverage amount) Optional Benefit: Travel Plus: (If Yes, then please mention coverage amount) No. of days: 2days and /7 days) Life Threatening Condition due to PED: (If Yes, then please mention coverage amount) Optional Benefit: Cancer Care: (If Yes, then please select- Option 1: Treated and curred cancer - 25% of SI per year;	Yes	No
	You	No	Note: Other Cancers diagnosed after policy issuance – up to SI	_	
Optional Benefit: New born Baby Cover:	Yes	No No	Option 2: Any Cancer - 2 times the base SI for lifetime.		
Optional Benefit: New born External Congenital Disease/Defect	s . res	INO	Optional Benefit: Out-patient Consultations:	Yes	No 🗌
(If Yes, then please mention coverage amount)	Yes	No No	Optional Benefit: Out-patient Dental and Vision Care:	Yes	No 🗌
Optional Benefit: New Born Vaccination: Optional Benefit: Assisted Reproductive Treatment:	Yes	No .	(If Yes, then please mention the amount opted		
(If Yes, then please mention coverage amount);	ies	INO L	Optional Benefit: Physical Consultations with General Physicians	s: Yes	 No 🗍
Waiting Period Months)			(If Yes, then please mention the amount opted)		
Optional Benefit: OPD Reward:	Yes	No 🗌			
(If Yes, then please mention coverage amount)	103	110	Optional Benefit: Physical Consultations with Specialist Doctors	: Yes	No
Optional Benefit: Policyholder – Child Protection:	Yes _	No 🗌	(If Yes, then please mention the amount opted)		
Optional Benefit: Spouse Care:	Yes	No 🗌	Optional Benefit: OPD Diagnostic tests:	Yes	No 🗌
Optional Benefit: Smart Select:	Yes	No 🗌	(If Yes, then please mention the amount opted)		
Optional Benefit: Room Rent Modification:	Yes	No 🗌	Optional Benefit: OPD Pharmacy:	Yes	No 🗌
(If Yes, then please select - General Ward max. up to Rs. 3000 per o	day 🗌		(If Yes, then please mention the amount opted)		
General ward			Optional Benefit: OPD Care:	Yes	No 🗌
Twin Sharing Room			(If Yes, then please mention the amount opted)		
Single Private Room)			Optional Benefit: Women Support Program:	Yes	No 🗌
Optional Benefit: PED Wait Period Modification:	Yes	No	Optional Benefit: Premium Freeze:	Yes	No 🗌
(If Yes, then please mention modified no. of months)			Note- Either Optional Benefit - 'Instant Cover' or '		
Optional Benefit: Named Ailment Wait Period Modification:	Yes 🗌	No 🗌	PED Wait Period Modification' can be opted but not both.		
(If Yes, then please mention modified no. of months)					
Optional Benefit: Initial Wait Period Modification:	Yes 🗌	No 🗌			
Optional Benefit: Deductible :	Yes 🗌	No 🗌			
(If yes, then please mention the deductible amount opted:					
Optional Benefit: Co-Payment:	Yes 🗌	No 🗌			
(If yes, then please mention the Co-pay %:		_			
Optional Benefit: Plus Benefit:	Yes	No 🗌			
(If Yes, then please mention coverage amount)					
Optional Benefit: Wellness Benefit:	Yes	No 🗌			
Optional Benefit: Women Care:	Yes	No 🗌			
(If Yes, then please mention coverage amount)					
Optional Benefit: Mental Health wellbeing:	Yes	No 🗌			
(If Yes, then please mention coverage amount)					
Acknowledgement for Brongest					
Acknowledgement for Proposal					
Please retain this counterfoil for your records We acknowledge the receipt of payment of ₹		vide Cash/	(On behalf of Care H Cheque/DD No./Authorization ID	ealth Insuran	ce Limited) from
Mr./MsPlo	ease note that	this is only an acknov	vledgement receipt and does not amount to acceptance of risk or commer	ncement of the	e Policy. The
			Date. The validity of this receipt is subject to realization of the proposal amour		
and issuance of the Policy shall be subject to receipt of the completed Pro	posal Form, p	remium payment, me	edical reports (wherever applicable) and underwriting decision of the Compa	any.	
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 receipt against the deposited cash against your Proposal. Any claim witho			nsurance limited branch or any authorized Bank branch, and we insist you to p e deposited cash will not be admitted.	olease ask for c	omputerize