

Proposal Form

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URN: CHIL / R / HE / 122 / 24-25
Proposal No.: _____

1. To be filled in by the Proposer 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. 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.
3. 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 "Proposer", "You" or "Your".

PROPOSER DETAILS

Name : (Mr./Ms./Mrs.)			
(First Name)		(Middle Name)	
(Last Name)			
Date of Birth / Incorporation (in case Proposer is an entity) : DDMMYYYY			
Proposer's Insurance Details with Care Insurance			
Name of Base Product:			
Base Policy Number:			
Correspondence Address :			
Locality :		City :	
Pin Code :		State :	
Landmark :		City :	
Permanent Address :		Mobile* :	
If same as above, please tick here <input type="checkbox"/>		State :	
Locality :		Mobile* :	
Pin Code :		Alternate No. :	
Telephone :		Email :	

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

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 <input type="checkbox"/>	No <input type="checkbox"/>	Aadhaar Number (last 4 digits): XXXXXXXXXX
(By signing the Proposal form I give my consent for using my Aadhaar No. for Authentication of my Aadhaar Details)				
CKYC				

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

DETAILS OF PREVIOUS OR EXISTING HEALTH INSURANCE

Please fill the following details with respect to health insurance proposals/policies with the Company or any other insurance companies

Particulars	Insured 1	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	<input type="checkbox"/> <input checked="" type="checkbox"/>					
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	<input type="checkbox"/> <input checked="" type="checkbox"/>					
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?	<input type="checkbox"/> <input checked="" type="checkbox"/>					
	Since _____ (DD/MM/YYYY)					

DECLARATION

- 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.
- 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.
- 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.
- 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.
- 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 including seeking and/ or sharing of my medical data through ABHA.

Date : / / (DD/MM/YYYY)

Signature of the Proposer/ Authorized Representative*:

Place :

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

*Only Applicable where proposer is a person with a disability and who has appointed an authorized representative.

PREMIUM PAYMENT INFORMATION

Payment By: Cash / Cheque / Demand Draft / Card / ECS (NACH) / Reward points / Wallet / Any other mode (Strike out whichever is not applicable)

Cheque / Demand Draft No. / Authorization ID :

Payment Amount (₹) : Premium 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 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 computerized 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)

Signature of the Proposer Authorized Representative* :

Place :

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

*Only Applicable where proposer is a person with a disability and who has appointed an authorized representative.

STATUTORY WARNING

Prohibition of Rebates

(Under Section 41 of Insurance Act 1938)

- 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.
- 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.

