

‘A’

Proposal No.:_____

- ## PROPOSER DETAILS

[illegible]

Gender :		Male		Female		Others			
Marital Status :		Single		Married		Divorced		Widow(er)Separated	
Mother's Name :									
PAN Number :									
Form 60 (only in case the customer does not have PAN no.) :		<input type="checkbox"/> Yes		<input type="checkbox"/> No		Nationality :			
						Aadhaar Number (last 4 digits):		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
						(By signing the Proposal form I give my consent for using my Aadhar No. for Authentication of my Aadhaar Details)			
CKYC									

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

☐ Yes ☐ No

[illegible]

☐ Yes ☐ No

<input type="checkbox"/> NDML – NSDL Data Management Limited	<input type="checkbox"/> CAMSRep- CAMS Insurance Repository & Services
<input type="checkbox"/> KARVY Insurance Repository Limited	<input type="checkbox"/> CIRL-Central Insurance Repository Limited

☐ Yes ☐ No

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

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

[illegible]

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[illegible]

Bank Account No:

IFSC/MICR Code: Bank Name:

[illegible]

Section I - Global Plus: Yes ☐ No ☐

Geographical Coverage: Worldwide excluding India ☐ WW excluding USA, Canada, India ☐

Plan Name: Basic ☐ Premium ☐ Elite ☐

Optional Benefit 1: Maternity Expenses Yes ☐ No ☐

Sum Insured: _____

Optional Benefit 2: OPD cover Yes ☐ No ☐

Sum Insured: _____

Optional Benefit 3: Modification of Waiting Period

Named Ailment Waiting Period Modification Yes ☐ No ☐

(If Yes, then please mention modified no. of months)

PED Waiting Period Modification Yes ☐ No ☐

(If Yes, then please mention modified no. of months) _____

Optional Benefit 4: International Second Opinion Yes ☐ No ☐

Optional Benefit 5: Modification of Advance Technology Methods Yes ☐ No ☐

(If Yes, then please select - 50% / 100% of SI)

Section 2-Plus: Yes ☐ No ☐

(If Yes, Please Specify the Base Benefits below, if opted)

Base Benefit I: Unlimited E-Consultations Yes ☐ No ☐

Base Benefit 2: Pre-Post Hospitalization Expenses Modification Yes ☐ No ☐

60/180 days ☐ 90/180 days ☐ No limit ☐

Are you applying for portability? Yes ☐

(If yes, please fill in the separate Portability Form)

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"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
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"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
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"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N 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.

