Car



Proposal Form

2.



URN: RHICL / R / HE / 040 / 19-20

Proposal No.:___

L.

To be filled in by the Proposer in CAPITAL 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".

3. 4.

FOR OFFICE USE ONLY																													
Intermediary Details																													
Intermediary Code :								Inte	erm	edia	iry N	lam	e:																
Intermediary RM Code :								Bra	anch	Со	de :																		
Customer Acc No. :																													
Care Health Insurance Branch Details																													
CHI RM Name :																											Τ		
Branch Code :						Clie	ent ID):						_					Re	ceip	t ID	:					-		
Details of 'Point of Sales' Person : (To be filled	l in it	f the	Policy i	s sourc	ed t	hro	ugh '	Poir	nt of	f Sal	es' P	erso	on)																
Please furnish at least one of the following details of	''Poir	nt of	Sales'' I	Person	:								,																
Aadhar Card No.:												P/		Card	No.	:													
PROPOSER DETAILS																													
Name : (Mr./Ms./Mrs.)																											T		
		(Firs	t Name)								1)	1idd	lle Na	me)									(Las	t Nar	ne)			_	
Correspondence Address :																							Ì						
	-													_												-	-		1
Locality :	-											Ci	ty :													1	-	-	
Pin Code :								Sta	te :																		-		
Landmark :	-	-																								1	<u> </u>	-	1
Permanent Address :																													
If same as above, please tick here																													
Locality :												Ci	ty :																
Pin Code :								Sta	ate :																				
Telephone :												Μ	obile	:															
Alternate No. :																													
Email :																													
Date of Birth / Incorporation (in case Proposer is an	enti	ty)		DM	M	Y	Y	Y	Y	1		G	ende	r:	Ma	le				Fem	ale			(Dthe	ers		1	
Marital Status : Single		rriec					Divo	orce	ed	_			V	Vido	w(e	r)			Se	para	ted		1						
PAN Number :									L	atio	nality	, .				•)											1		
Form 60 (only in case the customer does not have PAN no.) :		Yes			1	N					ar N		ber :										-		-	+	+	-	-
					J		-				e Proposi			consent	t for usin	g my Aa	idhaar N	o. for Ai	thentica	ation of n	ny Aadh	l iaar Det	tails)						
Mother's Name :																													
Would you like to opt for Electronic Policy Issuance thro	bugh	ane	-Insurar	ce Acc	ount	t (el	A) of	anl	Insui	ranc	e Rej	pos	itory	?			Ye	s					N	0					
If you have an eIA, please provide following details:																													
I) Name of Insurance Repository:																													
ii) elANo:																													
iii) Name as appearing in elA :																													
If you do not have an eIA, would you like to open an account?											No)																	
If Yes, choose any one Insurance Repository:										<u> </u>	N400		<u> </u>				6												
NDML-NSDL Data Management Limited											MSR											、 、							
Karvy Insurance Repository Limited											L-Ce	entr	al Ins	urar	nce H	lepc	sitor	°y Lii	nıte	d(C	DSL	_)							
Help us preserve the environment by opting to receive			lated info			sof	tcop	y/vi	aem							Yes					1	No							
Would you like to Subscribe to important alert on What	itsap	p?		Ye	es					1	No																		

Jul/20 /er:

POLICY DE	TAILS	;																											
Plan Opted :																													
Sum Insured (in R	s.):										Ter	lure	:			l Yea	ır 🗆	1		2`	Year			3	l I Year	•			
Cover Type:	- /		Inc	lividu	ual [1	Floater	-			-													-					
Optional Cover (Y	és [No		·																				
Details of Optional		•	exure - I	_	és [Vec plac	oo fill	lint			to D	o unt o lo	lite	Faire											
Are you applying	ior portai	Dility:			es 🗋		INO		(11	yes, plea	ise iii	i ir i u	ie se	epara	lero	ortad	onity	FOIT	n)										
NOMINEE	DETAI	LS																											
			1	Nom	ninee	Name								D	ate	of Bir	rth (DD	/MM/Y	ſΥΥ	Y)		Rel	ations	ship	with	Prop	oser	
*If the Nominee is of .	Age 18 year	s or less, Nam	e of Appo	intee a	and Re	lationship	with Minor:																						
			A	٩рро	intee	e Name								D	ate	of Bir	rth (DD	/MM/Y	ſΥΥ	Y)		R	elatio	nship	o wit	n Mi	nor	
In event of the death of Nominee for all the oth	of the Propo	ser any payme	nt due und	ler the	Policy	shall bec	ome payable t	o the	Nominee	proposed	in this	Prop	osal F	Form. T	he re	ceipt c	of the	proc	eeds by t	the N	Jomin	lee wou	ıld be	sufficier	nt disc	harge	of the	Com	pany. The
Nominee for all the oth	ner person(s) proposed to t	be insured :	shall be	e the P	roposer h	imself.																						
DETAILS O	FTHE	PROPO	DSED	то	BE	เทรเ		NC	LUDI	NG PI	ROI	PO	SEI	R															
Insured I : Na	me : Mr./I	Ms./Mrs.																											
Height	cms	Marital St	atus						Date c	of Birth	D	D	M	M	Y	Y	Y	Y	Annı	ual I	ncor	me (In	Lacs)	₹					
Weight	kg	Gender	Ma	le 🗌		Fema	e 🗌	Ot	thers [,			A	adha	ar N	10.											
Nominee (Relationsh	ip with Insured	i) :			Rela	ationshi	p with Pro	pos	er:				Cit	y of F	Resid	dence	e :			,			ŀ	f PEP	*:	Yes		No	
Insured 2 : Na	me : Mr./I	Ms./Mrs.																											
Height	cms	Marital St	atus						Date c	of Birth	D	D	M	M	Y	Y	Y	Y	Annı	ual I	ncor	me (In	Lacs) :	₹					
Weight	kg	Gender	Ma	le 🗌		Fema	e 🗌	Ot	thers [A	adha	ar N	10.											
Nominee (Relationsh					Rela	ationshi	p with Pro	pos	er:				Cit	y of F	Resid	dence	e :						ŀ	f PEP	*:	Yes		No	
Insured 3 : Na		1																									_		
Height	cms	Marital St								of Birth	D	D	M	M	Y	Υ	Y	Y	Annı	ual I	ncor	me (In	Lacs) :	₹			_	_	
Weight	kg	Gender	Ma	le 🗌		Fema	e 🗌	Ot	thers [adha		10.					_						
Nominee (Relationsh					Rela	ationshi	p with Pro	pos	er:				Cit	y of F	Resid	dence	e :							f PEP	*:	Yes		No	
Insured 4 : Na		1		_													~										_	_	
Height	cms	Marital St	1							of Birth	D	D	Μ	M	Y.	Y	Y	Y	Annı	ual I	ncor	me (In	Lacs) :	₹			_	_	
Weight	kg	Gender	Ma	le L		Fema			thers [01			adha		10.											
Nominee (Relationsh					Rela	ationshi	p with Pro	pos	er:				Cit	y of F	Kesi	dence	e :						I	f PEP*	*:	Yes		No	
Insured 5 : Na		Marital St						_		C Direth					\sim		\sim	\sim									_	_	
Height	cms kø				 ¬	Fema			thers	of Birth			*		1	adha:	1 		Annu	uari	ncor	me (In	Lacs) :	₹			_	_	
Weight Nominee (Relationsh	0	Gender	Ma				p with Pro						Cit	y of I				10.					-	f PEP	*.	Yes		No	
Insured 6 : Nat					INCI			pos						.y Of I	VE SI										•	ies			
Height	cms	Marital St	atus						Date c	of Birth			Μ	I M	Y	Y	Y	Y	Annı	ual I	ncor	me (In	lacs):	₹			+	+	
Weight	kg	Gender		le 🗌]	Femal	e 🗌	Ot	thers				<u> </u>		A	adha	ar N	10.				- (·					
Nominee (Relationsh	0	i) :			Rela	ationshi	p with Pro		er:				Cit	y of F	Resid	dence	e :						-	f PEP	*:	Yes		No	
*Have you ever b	een entru	sted with pr	ominen	t pub	lic fur	nctions,	forexample	e, He	eads of S	State or	of G	iove	rnm	, ient, s	senia	or po	olitici	ans,	senior	r go	vern	ment	, jud	icial c				icials,	senior
executives of sta	te owned	corporation	ns or imp	oorta	ant po	olitical pa	irty officials	ò.												-									
MEDICAL /	LIFES	TYLE RI	ELAT	ED	INF	ORM	ATION																						
Particulars									Insur	ed I	Ir	nsu	red	2		nsui	red	3	Ir	nsu	red	4	Ir	sure	d 5		In	sure	ed 6
Does any p Diagnosed/Suffer conditions: If ye section below:	red/Treat	ed/Taken N	Medicati	on f	or ar	ný of tl	ne follówir	ng																					
I. Cancer, tumo	r, polyp o	r cyst							Y Since_	Ν		Y ince		Ν	1 5	Y Since		Ν	Sii	nce <u></u>		N	Si	nce_]	Y Sin] ce	Ν
	 Any heart disease or disorder, chest pain or discomfort, irregula heartbeats, palpatations or heart murmur 					ar	Y Since_	Ν		Y ince		Ν		Y Since <u>,</u>		Ν	Si	nce <u></u>		N	Si	nce]	Y Sin] ce	Ν		
3. Hypertension	Hypertension / High Blood Pressure(BP)/ High Cholestrol						Y Since_	Ν		Y ince		Ν	1 -	Y Since <u>,</u>		Ν	Sii	nce <u></u>		Ν	Si	nce_			⊻ Sin] ce	Ν		

	Asthma / Tuberculosis (TB) / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease?		Y N	Y N	Y N	Y N	Y N
		Since	Since	Since	Since	Since	Since
	Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison disease / Pitutiary tumor/ disease or any other disorder of Endocrir		Y N	Y N	Y N	Y N	Y N
	system?	Since	Since	Since	Since	Since	Since

6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin medication	or Y N	YN	YN	YN	YN	YN
inculation	Since	Since	Since	Since	Since	Since
7. Motor Neuron Disease/ Muscular dystrophies/ Myasthnia Gravis any other disease of Neuromuscular system (muscles and/or nervo		Y N	Y N	Y N	Y N	Y N
system)	Since	Since	Since	Since	Since	Since
8. Stroke/ Paralysis/ Transient Ischemic Attack/ Multiple Scleros		Y N	Y N	Y N	Y N	Y N
Epilepsy/ Mental-Psychiatric illness/ Parkinsonism/ Alzeihmer Depression / Dementia or any other disease of Brain and Nervous Syste		Since	Since	Since	Since	Since
9. Cirrhosis / Hepatitis / Wilson's disease / Pancreatitis / Liver disease Crohn's disease / Ulcerative Colitis /Piles or any other disease		YN	Y N	Y N	Y N	Y N
Mouth, Esophagus, Liver, Gall bladder, Stomach or Intestines or a		Since	Since	Since	Since	Since
other part of Digestive System?						
10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Diseas Prostate Disease or any other disease of Kidney, Urinary Tract	e/ Y N	Y N	Y N	YN	YN	Y N
reproductive organs?	Since	Since	Since	Since	Since	Since
11. HIV/SLE/ Arthiritis/ Scleroderma / Psoriasis/ bleeding or clotti		Y N	Y N	Y N	Y N	YN
disorders or any other diseases of Blood, Bone marrow/ Immunity Skin.	Since	Since	Since	Since	Since	Since
12. Disease or disorder of eye, ear, nose or throat (except any sight relat	ed Y N	Y N	Y N	Y N	Y N	Y N
problems corrected by prescription lenses)?	Since	Since	Since	Since	Since	Since
13. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use ar	Y Y N	Y N	Y N	Y N	Y N	Y N
recreational drugs? If 'Yes' then please indicate the following:	Since	Since	Since	Since	Since	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)						
14. Any other disease / health adversity / injury/ condition / treatment no	+ Y N	Y N	Y N	YN	YN	YN
mentioned above?	Since	Since	Since	Since	Since	Since
15. Has any of the Proposed to be Insured been hospitalize						
/recommended to take investigations/medication or has been under	er 🛛 🕅	Y N	Y N	YN	YN	YN
any prolonged treatment/ undergone surgery for any illness/inju other than for childbirth/minor injuries?	Y Since	Since	Since	Since	Since	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 EXISITING DISEASE WHICH IS NOT MENTIONED IN THE ABOVE LIST)

DETAILS OF PREVIOUS OR EXISTING HEALTH INSURANCE

Please fill the following details with respect to health insurance proposals/	policies with the (Company or any c	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	YN	YN	Y N	Y N	YN	YN
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	Y N	Y N	Y N	Y N	Y N	YN
Is any of the person(s) proposed for insurance covered under any other	Y N	Y N	Y N	Y N	Y N	YN
health insurance policy with the Company or any other Company without break?	Since	Since	Since	Since	Since	Since
Diedn:	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)		(DD/MM/YYYY)	

ATTENDING PHYSICIAN'S DETAILS

Name of Family Physician :																							
			(First	Nan	ne)						(Mic	idle i	Nam	e)				(L	ast N	Jame	e)		
Contact Number :								En	nail :														

 Care Health Insurance Limited (Formerly known as Religare Health Insurance Company Limited)

 Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019
 Corresp. Office: Unit No. 604 - 607, 6th Floor, Tower C, Unitech Cyber Park, Sector-39, Gurugram -122001 (Haryana)

 Website: www.careinsurance.com
 E-mail: customerfirst@careinsurance.com
 Call us: 1800-102-6655

 CIN: U66000DL2007PLC161503
 UIN: RHIHLIP21017V052021
 IRDA Registration No. - 148

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.

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 C. 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. lauthorize 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. e. vauthority.

UI	Cia	unins secure	incincai		JVCII	inner	itaiai	iu/ c		cgui	ator	yau	uiio
Date	:		/	/			(DD	/MM/	/YY	YY)			
Place	:												

Signature of the Proposer :__

(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/YYY) Signature of the Proposer :													
Date :													
PREMIUM PAYMENT INFORMATION													
Payment By: Cash / Cheque / Demand Draft / Card /ECS (NACH) (Strike out whichever is not applicable)													
Premium payment mode: Single 🗌 Monthly 🗌 Quarterly 🗌 Half-yearly 🗌 (🗹 Ti	ck whichever is applicable)												

1 /	0	,	, ,			11 /		
Cheque / Demand Draft	No. / Authorizatio	on ID :						
Payment Amount (₹) :			Prer	nium Amoun	t (₹) :			
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.**"

(If the premium amount is shared by a co-proposer, kindly fill details in Annexure - II)

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 agains 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)

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

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 :	Signature :	
SP Name : _	 SP Code:	

ANNEXURE – I: OPTIONAL COVERS				
¦ Global Coverage – Total	: Y N	International Second Opinion :		
Air Ambulance Cover	: Y N	Extension of Global Coverage : Y		
Deductible Option	: Y N	If Yes, then please mention Deductible (in INR):		
No Claim Bonus Super	: Y N	Everyday Care : Y N		
Unlimited Automatic Recharge	: Y N			
Personal Accident	: Y N			
If Yes, then please fill the following details	5 :			
a. Amount opted for the Proposer (in Rs.)	:			
b. Additional Persons to be covered	: Spo	use Children		
c. Does your job require you to be involved with any hazardous activity, significant manual labor, operating heavy machinery, handling hazardous material, working at heights / underground / construction sites, oil rigging, high voltage, high temperature, working in aircrafts or sea-going vessels or adventure sports or armed forces? : 🛐 🔃				
OPD Care	: Y N	If Yes, then please mention the amount opted (in Rs.) :		
Daily Allowance+	: Y N	If Yes, then please mention the amount opted (in Rs.) :		
Travel Plus	: Y N	Smart Select : Y		
Additional Sum Insured for Accidental Ho	spitalization :	Y N Reduction in PED Wait Period : Y N		

Acknowledgement for Propos	a
Please retain this counterfoil for your records	

(On behalf of Care Health Insurance Limited)

from

vide Cash/Cheque/DD No./Authorization ID_ We acknowledge the receipt of payment of $\overline{\mathbf{R}}_{-}$ 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.

Signature of the Representative :

Proposal No.:

Name of the Representative : _

Insurance is a subject matter of solicitation. IRDA 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.

Care Health Insurance Limited (Formerly known as Religare Health Insurance Company Limited) Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019 Corresp. Office: Unit No. 604 - 607, 6th Floor, Tower C, Unitech Cyber Park, Sector-39, Gurugram -122001 (Haryana) Website: www.careinsurance.com E-mail: customerfirst@careinsurance.com Call us: 1800-102-4488 | 1800-102-6655 CIN: U66000DL2007PLC161503 UIN: RHIHLIP21017V052021 IRDA Registration No. - 148