

Proposal Form - "Care Advantage"

In reference to your online proposal (1120044008823) for "Care Advantage" Comprehensive Health Insurance policy, please find below the details as provided by you:

Proposer Details

Name	Address	Date of Birth	Mobile
MR. Pawan pratap Singh	Village+Post-rajawali, Tundla , FIROZABAD, UTTAR PRADESH, 283204	20-JUL-1980	XXXXXX1714

Landline	E-mail	Nominee Name	Nominee DOB	PAN Details
	paw*****@gmail.com	Pankaj devi	13/08/1980	Not Available

Details of the Persons be Insured

Relation	Name	Date of Birth	Height (cm)	Weight (kg)	Pre-existing Diseases
SELF	MR. Pawan pratap Singh	20-JUL-1980	178	80	NONE
SON	MR. Ashish Pratap Singh	16-NOV-2004	173	61	NONE
SPOUSE	MS. Pankaj Devi	13-AUG-1980	152	45	NONE
SON	MR. Praval tej pratap Singh	06-JUL-2002	170	73	NONE

Additional Details

A. Does any person(s) to be insured has any pre-existing diseases?

MS. Pankaj Devi	MR. Ashish Pratap Singh	MR. Pawan pratap Singh	MR. Praval tej pratap Singh		
NO	NO	NO	NO		

B. Have any of the person(s) to be insured ever filed a claim with their current/ previous insurer ?

MS. Pankaj Devi	MR. Ashish Pratap Singh	MR. Pawan pratap Singh	MR. Praval tej pratap Singh		
NO	NO	NO	NO		

C. Has any of your proposal(s) for Health insurance been declined, cancelled or charged a higher premium ?

MS. Pankaj Devi	MR. Ashish Pratap Singh	MR. Pawan pratap Singh	MR. Praval tej pratap Singh		
NO	NO	NO	NO		

D. Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company ?

MS. Pankaj Devi	MR. Ashish Pratap Singh	MR. Pawan pratap Singh	MR. Praval tej pratap Singh		
NO	NO	NO	NO		

You agreed to following terms & conditions of the purchase of policy

- a. I have read and understood the brochure/prospectus/sales literature/Terms and Conditions of the Policy and confirm to abide by the same.
- b. Receipt of proposal form by the Company shall not be construed as acceptance of proposal. Commencement of risk under the Policy shall be subject to realization of full premium and individual underwriting by the Company. The Company at its sole discretion reserves the right to accept or reject or load any proposal. Policy would start from the date as specified in the Policy Certificate.
- c. I understand that the Policy Period Start Date as specified in the Policy Certificate shall be from the 00:00 hours of the next day of the Proposal receipt at branch, proposed policy period start date as opted by me or cheque date, whichever is later.
- d. I understand that the Policy shall become void at the Company's option, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure of any material fact, in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by me or anyone acting on my behalf.
- e. I hereby declare that the lives proposed to be insured would submit to medical examinations before the nominated doctors of the Company or undergo diagnostic or other medical tests, as suggested by the Company for its underwriting.
- f. I consent to and authorize the Company and/or any of its authorized representative agents to seek medical information from any hospital/medical practitioner or any other related entity that I have attended or may attend in future concerning any illness or injury.
- g. I consent to provide a valid age proof and identity proof at the time of claims or any other time when required by the Company.
- h. I authorize the Company to exchange, share or part with the information relating to myself/person(s) to be insured with any external entity other than regulatory and statutory bodies, as may be required and I will not hold the Company or its agents liable for use/sharing of this information.
- i. I/We agree and undertake to convey to the Company any change/alterations carried out in the risk proposed for insurance after submission of this proposal form.
- j. I/We consent to receive information from the Company through physical, electronic or telecommunication means from time to time. The undersigned hereby declare on my behalf and on behalf of each of the persons proposed to be insured that the above statements and particulars are true, accurate and complete and correct in all respects and that there is all information which is relevant to this proposal that has been disclosed and not withheld from the Company. I declare that the money used to make the premium payment has not been derived from any illegal activity or unaccounted funds. I further declare and agree that this declaration and the answers given above shall be held to be promissory and shall be the basis of the contract between me/us and the Company.

You also agreed to receive service SMS and E-mail alerts.

Proposer's (Signature)

Servicing Branch : NA,XXXXXXXXXX,XXXXXXXXXX(00) - 0

Care Health Insurance Company Limited

Servicing Branch : NA,XXXXXXXXXX,XXXXXXXXXX(00) - 0

Correspondence address : Care Health Insurance Limited, Unit no 604 - 607, 6th Floor, Tower C, Unitech Cyber Park, Sector 39, Gurgaon - 122001.

Contact No : 1800-102-4488 Fax:1800-200-6677

Website : www.careinsurance.com RCM Applicability - NA

SAC and Description of Service: 997133- Accident and Health Insurance Services.

Email : customerfirst@careinsurance.com Consolidated Stamp Duty paid vide F.No.10 (17685)/COS(HQ)/CD dated 10th Jan 2015

GST Registration No : XXXXXXXXXXXX

IRDA Registration Number - 148 UIN : IRDA/NL-HLT/RHI/PP/ V.I/255/13-14