JOY

carē HEALTH INSURANCE

# Proposal Form

'L'

URN : RHICL / R / HE / 017 / 17-18

Proposal No.:_____

1. To be filled in by 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, please provide further details on a separate sheet. All attached documents form part of this Proposal.

## FOR OFFICE USE ONLY

### Intermediary Details

| | | | |
|---|---|---|---|
| Intermediary Code : | | Intermediary Name : | |
| Intermediary RM Code : | | Branch Code : | |
| Customer Acc No. : | | | |

### Care Health Insurance Branch Details

| | | | |
|---|---|---|---|
| CHI RM Name : | | | |
| Branch Code : | | Client ID : | ceipt ID : |

## PROPOSER DETAILS

| | |
|---|---|
| Name : (Mr./Ms./Mrs.) | |
| | (First Name) (Middle N e) Na e) |
| Correspondence Address : | |
| Locality : | City : |
| Pin Code : | ate : |
| Landmark : | |
| Permanent Address : If same as above, please tick here ☐ | |
| Locality : | City : |
| Pin Code : | : |
| Telephone : | Mobi |
| Email : | |

Date of Birth / Incorporation (in case Proposer is an ent : D D M M Y Y Y Y Gender : Male ☐ Female ☐

Marital Status : Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated ☐

| | | | |
|---|---|---|---|
| PAN Number : | | Nationality : | |
| Form 60 (only in case the customer does not have PAN no.) : | ☐ Yes ☐ No | Aadhaar Number : | |
| | | (By signing the Proposal form I give my consent for using my Aadhaar No. for Authentication of my Aadhaar Details) | |
| Mother's Name : | | | |

Would you like to opt for Electronic Policy uance through a urance Account ( A) of an Insurance Repository? Yes ☐ No ☐

If you have an eIA, please provide following ails:

| | |
|---|---|
| I) Name of Insurance Repository : | |
| ii) eIA No : | |
| iii) Name as pearing in eIA : | |

If you do no ave an eIA, would you like to open ar count? ☐ Yes ☐ No

If Yes, choos ny one Insurance R y:

| | |
|---|---|
| ☐ NDML- anagement ted | ☐ CAMSRep- CAMS Repository Services Limited |
| ☐ Karvy Insurance Repository Limited | ☐ CIRL-Central Insurance Repository Limited ( CDSL) |

## POLICY DETAILS

| | | | | | |
|---|---|---|---|---|---|
| Proposed Policy Period Start Date : D D M M Y Y Y Y | | | | | |
| Plan Opted : | ☐ Joy Today | ☐ Joy Tomorrow | Sum Insured (in Rs.) : | ☐ 3 Lac | ☐ 5 Lac |
| Tenure (applicable only for 'Joy Tomorrow') : | ☐ 1 Year | ☐ 2 Year | ☐ 3 Year | | |
| Cover Type : | ☐ Individual | ☐ Floater | (in case of Floater, 2 Adults implies 1 Male & 1 Female) | | |
| Optional Cover No Claim Bonanza opted : | ☐ Yes | ☐ No | | | |
| Are you applying for portability? | ☐ Yes | ☐ No | (If yes, please fill in the separate Portability Form) | | |

## NOMINEE DETAILS

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

*If the Nominee is of Age 18 years or less, Name of Appointee and Relationship with Minor:



Ver: Jul/20

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

In event of the death of the Proposer any payment due under the policy shall become payable to the nominee proposed in this form. The receipt of the proceeds by the Nominee would be sufficient discharge to the company. Nominee for all the other person(s) proposed to be insured shall be the Proposer himself.

## DETAILS OF THE PERSONS TO BE INSURED INCLUDING PROPOSER

| | | | |
|---|---|---|---|
| **Insured 1 :** Name : Mr./Ms./Mrs. | | | |
| Marital Status | Date of Birth D D M M Y Y Y Y | Relationship with Proposer : | |
| Gender Male ☐ Female ☐ | Aadhaar No. (Optional) | | If PEP* : Yes ☐ No ☐ |
| **Insured 2 :** Name : Mr./Ms./Mrs. | | | |
| Marital Status | Date of Birth D D M M Y Y Y Y | Relationship with Proposer : | |
| Gender Male ☐ Female ☐ | Aadhaar No. (Optional) | | If PEP* : Yes ☐ No ☐ |
| **Insured 3 :** Name : Mr./Ms./Mrs. | | | |
| Marital Status | Date of Birth D D M M Y Y Y Y | Relationship with Proposer : | |
| Gender Male ☐ Female ☐ | Aadhaar No. (Optional) | | If PEP* : Yes ☐ No ☐ |
| **Insured 4 :** Name : Mr./Ms./Mrs. | | | |
| Marital Status | Date of Birth D D M M Y Y Y Y | Relationship with Proposer : | |
| Gender Male ☐ Female ☐ | Aadhaar No. (Optional) | | If PEP* : Yes ☐ No ☐ |
| **Insured 5 :** Name : Mr./Ms./Mrs. | | | |
| Marital Status | Date of Birth D D M M Y Y Y Y | Relationship with Proposer : | |
| Gender Male ☐ Female ☐ | Aadhaar No. (Optional) | | If PEP* : Yes ☐ No ☐ |
| **Insured 6 :** Name : Mr./Ms./Mrs. | | | |
| Marital Status | Date of Birth D D M M Y Y Y Y | Relationship with Proposer : | |
| Gender Male ☐ Female ☐ | Aadhaar No. (Optional) | | If PEP* : Yes ☐ No ☐ |

*Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations or important political party officials.

## MEDICAL / LIFESTYLE RELATED INFORMATION

| Particulars | Insured 1 | Insured 2 | Insured 3 | Insured 4 | Insured 5 | Insured 6 |
|---|---|---|---|---|---|---|
| Does any proposed insured currently or in past Diagnosed/Suffered/Treated/Taken Medication for any of the following conditions: If yes, please provide details in the additional information section below: | | | | | | |
| 1. Cancer, tumor, polyp or cyst | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 2. Any heart disease or disorder, chest pain or discomfort, irregular heart beats, palpatations or heart murmur | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 3. Hypertension / High Blood Pressure(BP)/ High Cholestrol | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 4. Asthma / Tuberculosis (TB) / COPD / Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease ? | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 5. Thyroid disease/ Cushing's disease/ Hypothyroid Disease/ Addison disease / Pituitary tumor/ disease or any other disorder of Endocrine system ? | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 7. Motor Neuron Disease/ Muscular dystrophy / Myasthnia Gravis or any other disease of Neuro-Muscular system (muscles and/or nervous system) | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 8. Stroke/ Paralysis/ Transient Ischemic Attack / Multiple Sclerosis/ Epilepsy/ Mental-Psychiatric illness/ Parkinsonism/ Alzeihmer's/ Depression / Dementia or any other disease of Brain and Nervous System? | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 9. Cirrhosis / Hepatitis / Wilson's disease / Pancreatitis / Liver disease / Crohn's disease / Ulcerative Colitis / Piles or any other disease of Mouth, Esophagus, Liver, Gall Bladder, Stomach or Intestines or any other part of Digestive System? | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs? | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 11. HIV/SLE/ Arthiritis/ Scleroderma / Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin. | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |
| 12. Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses)? | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ | Y N Since_____ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please indicate the following:<br>- Hard Liquor (No. of Pegs in 30 ml per week)<br>- Beer(Bottles/ml per week)<br>- Wine( Glasses/ml per week)<br>- Smoking (no. of Sticks per day)<br>- Gutka/Pan Masala/Chewing Tobacco(Sachets/Grams per day) | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ |
| 14. Any other disease / health adversity / injury/ condition / treatment not mentioned above? | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ |
| 15. 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<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ | Y N<br>Since_____ |
| For Female Insured only :<br>a. Any complications in past pregnancy? If yes, please share the premature delivery report.<br>b. Are you pregnant currently? If yes, please share ANC records. | Y N<br>Y N | Y N<br>Y N | Y N<br>Y N | Y N<br>Y N | Y N<br>Y N | Y N<br>Y N |

**Note:** The Company shall cancel your proposal and refund the premium amount (after deducting cost of medical tests, if any) in case of incompleteness or any pregnancy highlighted or any other reason.

## ADDITIONAL INFORMATION (IF YOUR ANSWER IS 'YES' TO ANY OF THE ABOVE QUESTIONS THE PROPOSED TO BE INSURED ARE SUFFERING FROM ANY OTHER PRE EXISITNG DISEASE WHICH IS NOT MENTIONED IN THE ABOVE LIST)

## DETAILS OF PREVIOUS OR EXISTING HEALTH INSURANCE / PORTABILITY

Please fill the following details W.r.t. health insurance proposal(s) / policy(ies) with the Company or any other insurance company

| Details | Insured 1 | Insured 2 | Insured 3 | Insured 4 | Insured 5 | Insured 6 |
|---|---|---|---|---|---|---|
| Have any of the persons to be insured ever filed a claim with their current/previous insurer? If Yes, please provide details on a separate sheet | Y N | Y N | Y N | Y N | Y N | Y N |
| 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 | Y N |
| Is any of the persons proposed for insurance covered under any other health insurance policy with the Company or any other Company without break? | Y N<br>Since_____<br>(DD/MM/YYYY) | Y N<br>Since_____<br>(DD/MM/YYYY) | Y N<br>Since_____<br>(DD/MM/YYYY) | Y N<br>Since_____<br>(DD/MM/YYYY) | Y N<br>Since_____<br>(DD/MM/YYYY) | Y N<br>Since_____<br>(DD/MM/YYYY) |
| Does your existing Health insurance policy cover Maternity? | Y N | Y N | Y N | Y N | Y N | Y N |

## ATTENDING PHYSICIAN'S DETAILS

| | | | |
|---|---|---|---|
| Name of Family Physician : | | | |
| | (First Name) | (Middle Name) | (Last Name) |
| Contact Number : | | Email : | |

## 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 shall 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.

c. 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.

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 any thing 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.

e. 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.

Date : / / (DD/MM/YYYY)

Signature of the Proposer :_____

Place :

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

## 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.

c. 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.

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.

e. 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.

Date : / / (DD/MM/YYYY)

Signature of the Proposer :_____

Place :

(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 offer any alternative payout option such as cheque/demand draft in spite of providing above information.

Date : / / (DD/MM/YYYY)

Signature of the Proposer :_____

Place :

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

## PREMIUM PAYMENT INFORMATION

Payment By Cash / Cheque / Demand Draft / Card (Strike out whichever is not applicable)

Cheque / Demand Draft No. / Authorization ID :

Payment Amount (₹) : Premium Amount (

Date : D D M M Y Y Y Y Bank Name :

In case of payment through Cheque / Demand Draft, the instrument should be drawn in favour of **"Care Health Insurance Ltd."**

**Key Exclusions :**

(I) Any disease contracted during the first 30 days of the policy start date, except those arising out of accident

(ii) 2 Year Wait Period : Non-infective arthritis/Joint replacement/Cataract/Piles/Fissure/Ear, nose and throat (ENT) disorders and Stones/Stones, etc.

(iii) Pre-existing Diseases : 48 months from the date of the first policy

(iv) Maternity Wait Period : Joy Today : 9 months / Joy Tomorrow : 24 months

(v) Permanent Exclusions : Non-allopathic treatment / Expenses attributable to suicide, attempted suicide, alcohol or drug use, misuse or abuse / Cost of spectacles, contact lenses / dental treatment / Medical expenses incurred for treatment of AIDS / Treatment arising from or traceable to pregnancy and childbirth, miscarriage, abortion and its consequences or relating to infertility and in vitro fertilization / Congenital disease

For a detailed set of exclusions, please log on to www.careinsurance.com.

**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.

## STATUTORY WARNING

**Prohibition of Rebates**

(Under Section 41 of Insurance Act 1938)

1. 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

I _____ (Full Name) in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/ Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form basis of the Contract of Insurance between the Company and the Proposer, if this proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/information/response(s) is/are given in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable as per Policy Terms and Conditions and furthermore in case of 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 : / / (DD/MM/YYYY)

Signature : _____

SP Name : _____

SP Code :

## ACKNOWLEDGEMENT FOR PROPOSAL

Please retain this counterfoil for your records

(On behalf of Care Health Insurance Limited)

We acknowledge the receipt of payment of ₹_____ vide Cash/Cheque/DD No./Authorization ID_____ from 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.

Proposal No.: _____

Signature of the Representative : _____

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.