RELIGARE Values that bind | Health Insurance

Ab Health Hamesha

Proposal Form - 'CARE'

Proposal No.:_____

For Office Use Only

Intermediary Details

Intermediary Name :

Intermediary Code : Intermediary RM Code :

Intermediary Branch Code: Customer Acc No.:

Religare Health Branch Details

RHIL RM Name :

Branch Code : Client ID : Receipt No.

1. To be filled by Proposer in CAPITAL LETTERS only. Use Black ink.
2. Religare Health Insurance Company 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 from you, if any, will be refunded without interest.

Proposer Details

Mr. Ms. Gender : M F

Name : (First Name) (Last Name)

Address :

City :

State : Pin Code :

Date of Birth : / / (DD/MM/YYYY)

Landline : - Mobile :

E-mail :

PAN : (Mandatory for premium above ₹49,999)

Mother's Maiden Name :

Marital Status : Married Unmarried Nationality :

Policy Details

Proposed Policy Period Start Date : / / (DD/MM/YYYY)

Plan Opted :

Sum Insured : Tenure : 1 Year 2 Year 3 Year

(Premium should be paid upfront)

Cover Type : Individual Floater

Are you applying for portability? Yes No

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

Nominee Details

Name :

Date of Birth : / / (DD/MM/YYYY) Relationship :

In the event of 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 other person(s) proposed to be insured shall be the proposer himself.

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Details of the Person to be Insured (Including Proposer)

Name	Date of Birth	Gender	Occupation	Height & Weight		Relation
Insured 1 :	(DD/MM/YY)	☐ M ☐ F		cms	kgs	
Insured 2 :	(DD/MM/YY)	☐ M ☐ F		cms	kgs	
Insured 3 :	(DD/MM/YY)	☐ M ☐ F		cms	kgs	
Insured 4 :	(DD/MM/YY)	☐ M ☐ F		cms	kgs	
Insured 5 :	(DD/MM/YY)	☐ M ☐ F		cms	kgs	
Insured 6 :	(DD/MM/YY)	☐ M ☐ F		cms	kgs	

We take pride in servicing our customers beyond expectation, always

Please ensure that all the details required below are filled sincerely & truly.

Pre-existing Disease Details

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Is any of the member proposed to be insured suffering from any illness or disease? if yes, please provide details.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Details	Existing since	Existing since	Existing since	Existing since	Existing since	Existing since
Diabetes	☐	☐	☐	☐	☐	☐
Hypertension/High Blood Pressure	☐	☐	☐	☐	☐	☐
Respiratory Disorders	☐	☐	☐	☐	☐	☐
HIV/AIDS/STD	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Cancer/Tumor	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Arthritis/Joint Pain	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Paralysis/Stroke	☐	☐	☐	☐	☐	☐
Congenital Disease	☐	☐	☐	☐	☐	☐
Others	☐	☐	☐	☐	☐	☐
* Has anyone been diagnosed/ hospitalized or under any treatment for any illness/injury during the last 48 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
* Has anyone been under any medication/tablets for any illness/injury ?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

* If yes, please specify details on a separate sheet.

Note :

The Company may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the members proposed to be insured). These loadings would be applied from the Policy Period Start Date including all subsequent renewals with the company.

Any loadings, if applicable, shall be suitably intimated to the proposer based on the assessment of the proposal form and medical tests. Proposer shall be required to pay the additional premium within 15 days of such intimation. The Company shall not be at any risk during this period. In the event of decline of proposal due to non-receipt of this additional premium within the stipulated time or due to any reason, Company shall cancel your proposal and refund the premium amount after deducting cost of medical tests, if any.

Details of Previous or Existing Health Insurance

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

	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	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has any proposal for Health insurance been declined, cancelled or charged a higher premium?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any of the persons proposed for insurance covered under any other health insurance policy with the Company?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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 punishable with fine, which may extend to five hundred rupees.

Premium Payment Information

Payment By : Cheque/Demand Draft No./Authorization ID/Transaction ID: ____________

Date : __ __ / __ __ / __ __ __ __ (DD/MM/YYYY) Premium Amount (₹) : ____________

Bank Name : ____________

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

Opt for auto renewal ☐ Yes ☐ No (If yes, please fill the ECS Mandate Form).

NEFT Details (For Claims and Refund Purposes)

Account No. : ____________ IFSC Code : ____________

Bank Name : ____________

Bank Branch Name : ____________

Name of Account Holder : ____________

I declare that the information given above is true and correct. I hereby authorize Religare Health Insurance Company Limited to directly credit payout/refund, if any, to the above mentioned account and I shall not hold Religare Health Insurance Company 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. Religare Health Insurance Company Limited reserves right to use any alternative payout option such as cheque/demand draft in spite of providing above information.

(* Please submit copy of cancelled cheque along with Proposal Form)

Date : __ __ / __ __ / __ __ __ __ Signature of the Proposer : ____________

Declaration

a. 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.

b. I/We further declare that I/We 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.

c. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

d. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority.

e. I have read and understood the brochure/prospectus/sales literature/Terms and Conditions of the Policy and confirm to abide by the same.

f. 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.

g. 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.

h. I/We 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 of any material information having been withheld by me/us or anyone acting on my/our behalf.

i. 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 wherever applicable.

j. I/We consent to receive information from the Company through physical, electronic or telecommunication means from time to time.

k. I consent to provide a valid age proof and identity proof at the time of claims or at other time when required by the Company.

l. I/we authorize the Company to use and disclose any personal information collected/available with the Company in relation to the persons to be insured (whether obtained with this Proposal or otherwise) to other underwriting companies, claim investigation companies/agencies, service provider, assistance company/any statutory body and insurance/re-insurance companies for the purpose of processing of this proposal and providing subsequent services.

m. Bonafide Source of funds for payment
   (i) I/we hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act, 2002 and applicable laws.
   (ii) I understand that the Company has the right to call for documents to establish sources of funds.
   (iii) The insurance company has right to cancel the insurance contract in case I am/have been found guilty by any competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

I/We 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/We am/are authorized to propose on behalf of these other persons.

I/We further declare, on my behalf and on behalf of each of the persons proposed to be insured that there is all information which is relevant to this proposal that has been disclosed and nothing withheld from the Company. 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.

Date : ☐☐/☐☐/☐☐☐☐ Signature of the Proposer : _____

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

Acknowledgement for Proposal

Please retain this counterfoil for your records (On behalf of Religare Health Insurance Company Limited)

We acknowledge the receipt of payment of ₹_____ vide 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 policy. Religare Health Insurance Company Limited is not liable for any claim between the time that the proposal amount is received and policy start date. The validity of receipt is subject to realization of proposal amount. Acceptance of proposal & issuance of Policy shall be subject to receipt of completed proposal form, premium payment, medical reports (wherever applicable) and underwriting decision of the Company.

NOT VALID AGAINST CASH

Proposal No.:_____ Signature of the Representative : _____

Name of the Representative : _____

Insurance is a subject matter of solicitation. IRDA Registration No. 148