

Proposal Form - 'SECURE'

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Proposal No.: _____

For Office Use Only
Intermediary Details

Intermediary Name : _____
 Intermediary Code : _____ Intermediary RM Code : _____
 Intermediary Branch Code : _____ Customer Acc No.: _____
 Loan Amount : _____ Loan Tenure : _____

- To be filled in by Proposer in CAPITAL LETTERS only.
- Religare Health Insurance Company Limited (the "Company") is under no obligation to accept any proposal for insurance or to issue a policy by mere submission of a completed proposal form and/or payment of proposal deposit towards the same. The Company retains the right in its sole and absolute discretion to issue a policy. The liability of the Company does not commence until this Proposal has been accepted and underwritten by the Company and premium received, including loadings, if any. You understand and agree that if the Company accepts a proposal for insurance, it shall be subject to the Policy Terms and Conditions and the Company shall have no liability whatsoever if the premium is not realized, or received in full or in time. 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.
- If there is insufficient space, please provide further details on a separate sheet. All attached documents form part of this Proposal.

Proposer Details

☐ Mr. ☐ Ms. Gender: ☐ M ☐ F
 Name : _____
 (First Name) (Last Name)
 Address : _____
 Landmark : _____
 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 : ☐ Single ☐ Married Nationality : _____

Nominee Details

Name : _____
 Date of Birth : ____/____/____ (DD/MM/YYYY) Relationship with Proposer : _____
 Appointee name : ☐ Mr. ☐ Ms. _____
 (Only when the Nominee is of Age 18 years or less)
 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.

Policy Details

Plan Opted : _____ Sum Insured : _____ Tenure: ☐ 1 Year ☐ 2 Year ☐ 3 Year
 Accidental Hospitalisation (Add on Benefit opted): ☐ Yes ☐ No

Details of Existing Personal Accident or Health Insurance Policy

Do you have an existing Personal Accident/Health Insurance Policy with Religare Health or any other Insurer? ☐ Yes ☐ No
 (If yes, please provide the Insurer Name, Policy No., Plan name and Sum Insured)

Details of the Persons to be Insured including Proposer

Details	Insured 1	Insured 2
Name		
Date of Birth (DD/MM/YYYY)		
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
Relationship with proposer		
Marital status		
Highest Educational Qualification		
Nominee Name and Relationship (Please mention the name and relation of guardian if nominee is a minor)		
Annual Income		
Nature of Job/Profession/Occupation (Please mention industry/business/nature of duties)		
Does your job require you to engage in significant manual labor or hazardous activities or requires handling hazardous material or working at significant heights or with high voltage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed or are under treatment for any terminal illness or any illness/disease restricting your activities (e.g. Epilepsy/Seizure disorder)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any existing Disability/Deformity (physical or mental impairment/infirmity or any condition hampering vision, hearing or mobility)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any company ever declined to issue/renew a Personal Accident policy for any proposed? If yes, please provide details	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Declaration

- I understand that the information provided by me will form the basis of the insurance policy, is subject to the board approval/underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- 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.
- 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.
- 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.
- I have read and understood the brochure/prospectus/sales literature/Terms and Conditions of the policy and confirm to abide by the same.
- I/We consent to receive information from the Company through physical, electronic or telecommunication means from time to time.
- Bona fide Source of funds for payment
 - 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.
 - I understand that the Company has the right to call for documents/proofs of funds.
 - 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 that there is all information which is relevant to this proposal that has been disclosed and not 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 : / /
Place :

Signature of the Proposer : _____

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

Premium Payment Information

Payment By : ☐ Cheque/Demand Draft/Card (strike out whichever is not applicable) Cheque/Demand Draft No./Authorization ID :
Date : / / (DD/MM/YYYY) Amount (₹) : _____ Premium Amount (₹) : _____
Bank Name : Sources of Funds : ☐ Salary ☐ Business ☐ Others (if others, please specify) _____
In case of payment by Cheque/Demand Draft, the instrument should be drawn in favour of **"Religare Health Insurance Company Ltd."**

Statutory Warning

Prohibition of Rebates (Under Section 44 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 punishable with fine, which may extend to five hundred rupees.

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./Card No. _____ 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