Proposal Form - 'JOY'

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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.:

Religare Health Branch Details

RHIL RM Name :

Branch Code : Client ID : Receip

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 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 same and the premium received (less cost 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 the Proposal.

Proposer Details

Mr. Ms. M/s. Gender : M

Name :

(First Name) (Middle Name) (Last Name)

Address :

City :

State : Pin Code :

Date of Birth/Incorporation (in case Proposer is an entity) : / / (DD/MM/YYYY)

Landline : - Mobile :

E-mail :

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

Mother's Maiden Name :

Marital Status : _____ Nationality :

Policy Details

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

Sum Insured : 3 Lac 5 Lac

Tenure : _____
(Premium should be paid upfront)

Cover Type : Individual Floater (in case of Floater, 2 Adults implies 1 Male & 1 Female)

Are you applying for portability? Yes No
(If yes, please fill in the separate Portability Form)

Optional Cover 'No Claim Bonanza' opted : Yes No

Nominee Details

Name :

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

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.

Details of the Person to be Insured (Including Proposer)

Name	Date of Birth	Gender	Marital Status	Relationship with Proposer
First Name : Last Name :	(DD/MM/YY)	☐ M ☐ F		
First Name : Last Name :	(DD/MM/YY)	☐ M ☐ F		
First Name : Last Name :	(DD/MM/YY)	☐ M ☐ F		
First Name : Last Name :	(DD/MM/YY)	☐ M ☐ F		
First Name : Last Name :	(DD/MM/YY)	☐ M ☐ F		
First Name : Last Name :	(DD/MM/YY)	☐ M ☐ F		

Pre-existing Disease Details

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
During the last 48 months has anyone been a) diagnosed/hospitalized under any treatment for any illness/injury	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) under any medication/tablets for any illness/injury? If yes, please specify details on a separate sheet	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pre-existing Disease(s) : E.g. 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	☐	☐	☐	☐	☐	☐
Month & Year when such Pre-existing Disease was first detected						
For Female Insured only : a) Any complications in past pregnancy? If yes, please share the premature delivery report	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Are you pregnant currently? If yes, please share ANC records	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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 discrepancy highlighted or any other reason.

Attending Physician's Details

Name of Family Physician : (First Name) (Last Name)

Contact Number : E-mail ID :

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.

Sr. #	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
Does your existing Health insurance policy cover Maternity benefit?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Premium Payment Information

Premium Amount : _____

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

Cheque/Demand Draft No./Authorization ID :

Date : / / (DD/MM/YYYY) Amount (`) :

Bank Name :

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

Key Exclusions

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

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

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

iv) Maternity Wait Period : Joy Today : 9 months

v) Permanent Exclusions : Non-allopathic treatment/Expenses attributable to self-inflicted injury (resulting from suicide, attempted suicide) or 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.religarehealthinsurance.com.

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.

Declaration

a. 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.

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

c. 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.

d. 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.

e. 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.

Date : / / (DD/MM/YYYY)

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 acknowledgment 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