RELIGARE Values that bind | Health Insurance

Ab Health Hamesha

## Proposal Form - 'ASSURE'

D

Proposal No. : _____

### For Office Use Only

**Intermediary Details**

Intermediary Name :

Intermediary Code : Intermediary RM Code :

Branch Code :

**Religare Health Branch Details**

RHIL RM Name :

Branch Code :

Client ID : Receipt ID :

1. To be filled by Proposer in CAPITAL LETTERS only.
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. 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.
3. 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. ☐ M/s Gender: ☐ ☐

Name :

(First Name) (Last Name)

☐ Mr. ☐ Ms.

Key Person Name :

(First Name) (Last Name)

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

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

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

Mother's Maiden Name :

Marital Status : ☐ Single ☐ Married

### Nominee Details

Name :

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

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 persons proposed to be insured shall be the Proposer himself.

### Policy Details

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

Sum Insured : Tenure : ☐ 1 Year ☐ 2 Year ☐ 3 Year Are you applying for portability? ☐ Yes ☐ No

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

### Details of the Person to be Insured (Including Proposer)

| Details | To be Insured 1 | To be Insured 2 |
|---|---|---|
| Name | (First Name) (Last Name) | (First Name) (Last Name) |
| Date of Birth (DD/MM/YYYY) | | |
| Gender (M/F) | ☐ M ☐ F | ☐ M ☐ F |
| Relationship with Proposer | | |
| Occupation | ☐ Self Employed ☐ Service | ☐ Self Employed ☐ Service |
| Are you suffering from any Pre-existing Disease? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Month and year when such Pre-existing Illness was first detected | | |
| Treatment(s) taken for the illness along with duration for which the treatment(s) medication was taken | | |
| Has anyone been diagnosed/hospitalized or under any treatment for any illness/injury during the last 48 months? If yes, please specify details on a separate sheet | ☐ Yes ☐ No | ☐ Yes ☐ No |

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**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. The proposer shall be required to pay an additional premium within 15 days of such intimation.

The Company shall not be at any risk during this period. In the event of non-receipt of this additional premium within the stipulated time or non acceptance of Proposal, 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(es) with the Company or any other insurance companies.

| Details | Insured 1 | Insured 2 |
|---|---|---|
| Existing Insurance Company | | |
| Policy no. | | |
| Policy Period - From<br>To | | |
| Sum Insured | | |
| Have any of the persons to be insured ever filed a claim with their current/previous insurer?<br>If Yes, please provide details on a separate sheet | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Has any proposal for Life, Accident, Disability cover, Critical Illness or any other Health-Related Insurance on your life ever been postponed, declined or accepted on special terms? If yes, give details including amount applied for | ☐ 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 |

## Attending Physician's Details

Name :

Contact No.: E-mail :

## Medical & Lifestyle Details

Please answer each of the following questions for and on behalf of the Insured. (You means the "Insured Person"). Each question needs to be answered "Yes" or "No", unless other options are provided.

| S.No. | Details | To be Insured 1 | To be Insured 2 |
|---|---|---|---|
| 1. | Are you now in good health and entirely free from any mental or physical impairments or deformities? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. | Height & Weight | _____(cms.) _____(Kg.) | _____(cms.) _____(Kg.) |
| 3. | How much weight have you lost or gained over the last 12 months?<br>Reason for weight change | _____(Kg.) | _____(Kg.) |
| 4. | Have you been hospitalized for treatment of an illness or injury? If yes, please provide details in a separate sheet | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. | Have you been aware or told you have the following : | | |
| | Heart Diseases | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Kidney/Lung/Liver Disease | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Cancer | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Diabetes | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | High Blood Pressure | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. | Have you been told that you require an impending hospital/surgical treatment? If Yes, please provide information in a separate sheet | ☐ Yes ☐ No | ☐ Yes ☐ No |

## Health Questionnaire

| S.No. | Question | To be Insured 1 | To be Insured 2 |
|---|---|---|---|
| 1. | Have you ever suffered or do you now suffer from | | |
| | Diseases of the circulatory system (e.g. heart trouble, chest pain, rheumatic fever, high blood pressure, diseases of the arteries and veins)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia or emphysema)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Diseases of the gastrointestinal system (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B, hepatitis C or other disorders of the liver, disorders of the gall bladder)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Diseases of the nervous system or mental disorders (e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches, Bacterial Meningitis, Multiple Sclerosis, Motor Neurone Disorder, nervous breakdown, depression or other mental or psychiatric disorder)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Diabetes mellitus, cancer or tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes or skin? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Liver Disease | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Lung Disease | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Chronic Relapsing Pancreatitis | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Any other diseases or ailments not mentioned above? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. | Have you or any of your immediate family members (father, mother, brother, or sister) have/had cancer, heart attack, or stroke and at what age? Prior to age 60? | ☐ Yes ☐ No | ☐ Yes ☐ No |

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| S.No. | Question | To be Insured 1 | To be Insured 2 |
|---|---|---|---|
| 3. | Have you ever had or been advised to have hospital treatment or surgery? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. | Have you ever had or been advised to have a blood test for AIDS or an AIDS-related condition or have you ever been refused as a blood donor? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. | In the past 5 years, have you consulted a physician for any reason or have you had any investigation such as blood or urine tests, X-rays, electrocardiograms, ultra sonograms, CT scans or biopsy, other than for routine purposes? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. | Have you ever received or do you now receive any personal accident, disability benefit, or disability-related payments? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 7. | Are you at present or any time in past were on any medication, special diet, or treatment? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 8. | Have you ever taken narcotics or other habit forming drugs or been treated or advised in connection with your alcohol consumption or the taking of drugs? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 9. | Do you participate or do you intend to participate in any hazardous sports or activities such as motor sports, parachuting, hang-gliding, or aviation except as a fare-paying passenger? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 10. | For females only: Are you pregnant ? If yes, please state how many months. Please state if you had any pregnancy related complication during your previous pregnancy/delivery? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 11. | Do you smoke or consume gutkha/pan masala or alcohol. If yes please indicate the name and quantity per week. | ☐ Yes ☐ No | ☐ Yes ☐ No |

**Note :**

If you answered "yes" to any of the above questions, please give complete details (including dates, duration and treatment, names and addresses of physicians) on a separate sheet and kindly attach the same.

## 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 any 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/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.

Date : ☐☐ / ☐☐ / ☐☐☐☐

Place : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Signature of the Proposer : _____

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

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## Payment Information

Premium Amount : | | | | | | | | | |

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

Cheque/Demand Draft No./Authorization ID : | | | | | | | | | | | | | | | | |

Date : | | | / | | | / | | | | (DD/MM/YYYY) Amount (INR) : _____

Bank Name : | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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

## 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.

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## 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._____ 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, 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