Proposal Form - 'CARE FREEDOM'

Q

Proposal No.:_____

For Office Use Only

Intermediary Details

Intermediary Code : Intermediary Name :

Partner RM Code : Partner Branch Code :

Customer Acc No. :

Religare Health Branch Details

RHIL RM Name :

Branch Code : Client ID : Receipt ID :

1. To be filled in by the Proposer in CAPITAL LETTERS only.
2. 1.Religare Health Insurance Company Limited (the "Company") is under no obligation to accept the 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 for You to complete Your answers, please use the Additional Information section. All attached documents form part of this Proposal Form.
4. The proposed policyholder will be referred to in this Proposal Form as "Proposer", "I", "Me" or "Your".

Proposer Details

☐ Mr. ☐ Ms. ☐ M/s Gender ☐ M ☐ F

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

Date of Birth/Incorporation (in case Proposer is) D D / M M / Y Y Y Y Nationality :

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

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

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

Mother's Maiden Name :

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.

We take pride in servicing our customers beyond expectation, always

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

Details of the Persons to be Insured including Proposer

Details		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name	(First Name)						
	(Middle Name)						
	(Last Name)						
Date of Birth (DD/MM/YYYY)							
Gender		M F	M F	M F	M F	M F	M F
Relationship with proposer							
Marital status							
Nominee (Relationship with Insured)							
Profession/Occupation - Self Employed - Service • Sales • Manufacturing • Others - House-spouse - Student - Retired - Not Employed		☐	☐	☐	☐	☐	☐
Annual Income (in Rs.) - Nil - Up to 3 Lacs - More than 3 Lacs and up to 6 Lacs - More than 6 Lacs and up to 15 Lacs - More than 15 Lacs		☐	☐	☐	☐	☐	☐
Height (in centimeters)							
Weight (in kilograms)							
Has any Proposed to be Insured been diagnosed with or suffered from/is suffering from or is currently under medication for the following? If Your response is yes to any of the following questions, please specify details of the same in the additional information section							
1. Cancer		Y N	Y N	Y N	Y N	Y N	Y N
2. Any cardiovascular/Heart Disease (including but not limited to Coronary artery disease/Rheumatic heart disease/Heart Attack or Myocardial infarction/Heart failure/Bypass Grafting or CABG/ Angioplasty or PTCA/Heart valve diseases/Pacemaker implantation)		Y N	Y N	Y N	Y N	Y N	Y N
3. Hypertension/High Blood Pressure		Y N	Y N	Y N	Y N	Y N	Y N
4. Any respiratory disease of Lungs, Pleura and airway (including but not limited to Asthma/Tuberculosis/Pleural effusion/ Bronchitis/Emphysema)		Y N	Y N	Y N	Y N	Y N	Y N
5. Any disorders of the endocrine system (including but not limited to Pituitary/Parathyroid/adrenal gland disorders)		Y N	Y N	Y N	Y N	Y N	Y N
6. Diabetes Mellitus type I, Diabetes on insulin or Diabetes associated with blindness or chronic foot ulcer		Y N	Y N	Y N	Y N	Y N	Y N
7. Any Neuromuscular (muscles or nervous system) disorder or Psychiatric disorders (including but not limited to Motor Neuron Disease, Muscular dystrophies, Epilepsy, Paralysis, Parkinsonism, multiple sclerosis, stroke, mental illness)		Y N	Y N	Y N	Y N	Y N	Y N
8. Chronic Pancreatitis or Chronic Liver disease (including but not limited to Cirrhosis/Hepatitis B or C/Willson's disease)		Y N	Y N	Y N	Y N	Y N	Y N
9. Any chronic Kidney Disease		Y N	Y N	Y N	Y N	Y N	Y N
10. Any disorders of Blood and/or Immunity (including but not limited to bleeding or clotting disorders, Systemic Lupus Erythematosus, Rheumatoid Arthritis, Crohn's disease, Ulcerative Colitis)		Y N	Y N	Y N	Y N	Y N	Y N

Details of the Persons to be Insured including Proposer

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
11. Have You smoked, consumed alcohol, or chewed tobacco, ghutka or paan or used any recreational drugs? If 'Yes' then please provide the frequency & amount consumed.	Y N	Y N	Y N	Y N	Y N	Y N
12. Any other disease/health adversity/condition/treatment not mentioned above?	Y N	Y N	Y N	Y N	Y N	Y N
13. Has any of the Proposed to be Insured been hospitalized or has been under any prolonged treatment for any illness/injury or has undergone surgery other than for childbirth/minor injuries?	Y N	Y N	Y N	Y N	Y N	Y N
14. Has any of the Proposed to be Insured consulted/taken treatment or recommended to take investigations/medication/surgery other than for childbirth/minor injuries?	Y N	Y N	Y N	Y N	Y N	Y N

Note: The Company shall reject Your proposal and refund the premium amount (after deducting cost of medical tests, if any) in case of incomplete information or any discrepancy highlighted or any other reason..

Additional Information : ____

____ (Please use a separate sheet if required)

Policy Details

Plan Opted: ____________ Sum Insured (in Rs.): ☐☐☐☐☐☐☐ Deductible (in Rs.): ☐☐☐☐☐☐☐

Co-payment (in %): ☐☐ Cover Type: ☐ Individual ☐ Floater Tenure: ☐ 1 Year ☐ 2 Year ☐ 3 Year

(Premium should be paid upfront)

Optional Cover - 1 : Good Health+ opted : ☐ Yes ☐ No (If Yes, then please mention the per consultation payable claim limit (in Rs.): ☐☐☐

Optional Cover - 2 : Home Care opted : ☐ Yes ☐ No

Optional Cover - 3 : Health Check+ opted : ☐ Yes ☐ No

(If Yes, then please tick which one : ☐ Diabetes Health Check-up ☐ Cardiac Health Check-up

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

Premium Payment Information

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

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Payment Amount (INR) : ☐☐☐☐☐☐ Premium 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 : 24 months from the date of the first policy

(iv) 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.

(v) Treatment/consultation in a hospital which is named in the negative list of hospitals.

For a detailed list of exclusions, please log on to www.religarehealthinsurance.com.

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 : | | | / | | | / | | | | |

Signature of the Proposer : _____

Place : _____

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

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 rebates 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 for Agents/Specified Person (SP) (for office use only)

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)m 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 contained in this Proposal Form/including addendum(s), affidavits, statement(s), submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and furthermore, if there has been a 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 premiums paid under the Policy may be forfeited to the Company.

License No. (Advisor/ Corporate Agent/ Broker/ Relationship Officer).

Date : | | | / | | | / | | | | |

Signature : _____

SP Name : _____

SP Code : | | | | | | | | | | | | | | |

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