Proposal Form - ' STUDENT EXPLORE'

S

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. Please answer all the questions fully and correctly. If any question does not apply, please mention 'Not Applicable' or 'NA'. Please fill in CAPITAL letters only.
2. 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. 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.
4. Please contact the Company's Offices for any doubts or clarifications.
5. All attached documents form part of this Proposal.
6. The proposer's age should above 18 years.

Proposer Details

☐ Mr. ☐ Ms. ☐ Gender ☐ M ☐ F

Name :

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

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

Policy Details

Policy Period Start Date : / / (DD/MM/YYYY) Policy Duration (in months) :

Geographical Scope : ☐ Worldwide excluding India ☐ Worldwide (excluding US, Canada and India)

Plan Opted : ☐ Start ☐ Plus ☐ Super ☐ Ultra

Purpose of Travel : ☐ Study ☐ Profession or semi professional sport ☐ Aviation training

The Proposed to be Insured may opt for Optional Cover 1, Optional Cover 2, Optional Cover 7, Optional Cover 8 & Optional Cover 11 only if it is a University requirement.

Optional Cover 1: Self-inflicted injury opted : ☐ Yes ☐ No

Optional Cover 2: HIV/AIDS Cover opted : ☐ Yes ☐ No

Optional Cover 4: Vision Care opted : ☐ Yes ☐ No

If Yes, then the Optional Cover opted is due to University requirement? ☐ Yes ☐ No

Optional Cover 8: Maternity & New Born Cover opted : ☐ Yes ☐ No

(If Yes, then the Sum Insured opted is US $ ☐☐☐☐☐☐, wait period opted is ☐☐ months, and the co-payment opted is ☐☐ %)

Optional Cover 11: Complete Pre-Existing Disease Cover in Life Threatening Medical Condition opted : ☐ Yes ☐ No

Optional Cover 3: Adventure Sports Injury opted : ☐ Yes ☐ No

Optional Cover 5: Home Care opted : ☐ Yes ☐ No

Optional Cover 6: Family Care opted : ☐ Yes ☐ No

(If Yes, then the Sum Insured opted is US $ ☐☐☐☐☐☐, wait period opted is ☐☐ months, and the co-payment opted is ☐☐ %)

Optional Cover 7: Maternity Cover opted : ☐ Yes ☐ No

(If Yes, then the Sum Insured opted is US $ ☐☐☐☐☐☐, wait period opted is ☐☐ months, and the co-payment opted is ☐☐ %)

Optional Cover 9: Co-payment Option opted : ☐ Yes ☐ No

(If Yes, then the Co-payment opted is ☐☐ %)

Optional Cover 10: Deductible Option opted : ☐ Yes ☐ No

(If Yes, then the Deductible opted is US $ ☐☐☐☐☐☐)

Details of the Person to be Insured (Including Proposer)

	Insured 1	Insured 2	Insured 3	Insured 4
Name				
Gender				
Date of Birth	(DD/MM/YY)	(DD/MM/YY)	(DD/MM/YY)	(DD/MM/YY)
Passport Number				
Sum Insured of Medical Expenses (in US $)	☐ 10,00,000 ☐ 5,00,000 ☐ 3,00,000 ☐ 1,00,000 ☐ 50,000	☐ 3,00,000 ☐ 1,00,000 ☐ 50,000	☐ 3,00,000 ☐ 1,00,000 ☐ 50,000	☐ 3,00,000 ☐ 1,00,000 ☐ 50,000
Relationship with Proposer				
Relationship with Student		Spouse	Son / Daughter	Son / Daughter
Pre-existing Disease (Please tick)	Existing since	Existing since	Existing since	Existing since
Cancer/Tumor	☐	☐	☐	☐
Coronary Artery Heart Disease	☐	☐	☐	☐
Insulin Dependent Diabetes	☐	☐	☐	☐
Paralysis/Stroke	☐	☐	☐	☐
Congenital Disease	☐	☐	☐	☐
HIV/AIDS/STD	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Thalassemia	☐	☐	☐	☐
Other (Please Specify)*	☐	☐	☐	☐
Month & Year when such Pre-existing Disease was first detected				

* In case the above named person(s) is/ are suffering from an illness/disease other than those referred above or have been diagnosed/ hospitalized or taken any treatment/medication for any illness/disease in the last 48 months, then please provide complete details.

Nominee Details

Name : ☐ Mr. ☐ Ms. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

Appointee Name : ☐ Mr. ☐ Ms. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(Only in cases where Nominee is minor)

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.

Additional Information

Educational Institute Details

Name of Educational Institute	Educational Course Details	Educational Institute Address	Country

Sponsor's Details

Sponsor's Name	Date of Birth	Relationship with insured	Address

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 therein will form 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, statements, 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 all 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 : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Premium Payment Information

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

Instrument No. :

Instrument Date : / / (DD/MM/YYYY) 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.**"

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 those 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 medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority.

Date : / /

Place :

Signature of the Proposer :

(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 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.

Acknowledgement for Customers

Please retain this counterfoil for your record

(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