Proposal Form - 'Group Care 360° Plus'

URN: CHIL / G / PK / 113 /23-24

Proposal No.:_____

For Office Use Only

Intermediary Details

Intermediary Name :

Intermediary Code : Intermediary RM Code :

Intermediary Branch Code : Business Sector :

Care Health Insurance Branch Details

Sales Manager Name :

Branch Code : Client ID : Receipt ID :

Please Note:

1. To be filled in by the Proposer in CAPITAL LETTERS only.
2. Care Health Insurance 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. 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", "You" or "Your".

Proposer Details

Full name of the Proposer/Entity :

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

Correspondence Address :

Locality : City :

Pin Code : State :

Landmark :

Permanent Address :
(if same as above please tick here ☐)

Locality : City :

Pin Code : State :

Landmark :

Contact Details: Land line (R) : (O) :
(STD Code) (STD Code)

Mobile No :

E-mail ID :

Identification No. / Bank Account No. / any other :

PAN (mandatory) : Please share the required KYC documents as per Appendix I (mandatory)

Do all the members proposed to be insured form part of one Group or Association or Corporate body? ☐ Yes ☐ No

Is the scheme contributory ☐ Yes ☐ No

SAMPLE

Details of the Proposed to be Insured

Please provide complete details of Proposed to be Insured as per Annexure- I attached

Note: The Company shall reject Your proposal and refund the premium amount in case of incompleteness or any discrepancy highlighted or any other reason.

Policy Details

Policy Period : From (00:00 hours) ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) To (midnight) ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Coverage Type : ☐ Individual ☐ Family

If Family coverage type is opted, then the Member Combination chosen: ☐ Members

Geographical Scope

☐ India ☐ Worldwide excluding India ☐ Worldwide excluding US, Canada, India

Details of Benefit(s) as per Final quote and/or Annexure – II

Past Policy and Claim Details

1. Kindly provide particulars for the past 3 (three) policy periods for which policy was availed.

Policy Period (From - To) (DD/MM/YYYY)	Name & Address of the Insurer	Policy No.	Total Premium	Total No. of claims (Paid + Outstanding)	Total Amount of claims (Paid+ Outstanding)	Total No. of Lives Insured (including endorsements at end of policy)	Name of TPA, if any
			₹	₹	₹		
			₹	₹	₹		
			₹	₹	₹		

2. Please provide details on the following condition(s)

Condition(s) applicable to your health insurance policy	Yes/No	Name of Insurance Company	Address
1. Declined to continue			
2. Not invited renewal			
3. Imposed any restrictions or special conditions			

Material Disclosures

Any additional information relevant to the policy applied for : _____

Note: Please use additional sheets if space is not sufficient to give details

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Declaration

a. I 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 am 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 Insurer and that the policy will come into force only after full payment of the premium chargeable.

c. I further declare that I 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 declare that I consent to the company seeking medical information from any doctor or hospital who / which at any time has attended on the person to be insured/ proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be assured / proposer and seeking information from any Insurer to whom an application for insurance on the person to be insured / proposer has been made for the purpose of underwriting the proposal and / or claim settlement.

e. I authorize the company to share information pertaining to my proposal including the medical records of the Insured/Proposer for the sole purpose of underwriting the proposal and / or claims settlement and with any Governmental and / or Regulatory authority.

f. I hereby consent to receiving information from Central CKYC Registry through SMS/Email on the above registered email address/number.

Date : / /

Place :

Signature of the Authorized Signatory : _____

(On behalf of all the Proposed to be Insured under the Policy)

Premium Payment Information

Premium Amount :

Payment By : Cheque / Demand Draft No. / Any other Mode (Strike out whichever is not applicable)

Cheque / Demand Draft No. / Authorization ID :

Date : / /

Payment Amount (INR) :

Bank Name :

In case of payment through Cheque/Demand Draft, the instrument should be drawn in favour of **"Care Health Insurance 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 liable for a penalty which may extend to ten lakh rupees.

Addendum - Vernacular Declaration

I _____, son/daughter of _____, resident of _____ declare that Ihave read out and fully explained the contents of the Proposal Form and all other accompanying documents in _____ language to the Proposer which is a language understood by him/her and is imperative for the Proposer to avail the insurance from the Company . The contents and import of the proposal have been fully understood by him/her and the replies have been recorded according to the information provided by the Proposer. The replies have also been read out to, fully understood and confirmed by the Proposer.

Date : / /

Place : _____

Name of the Declarant : _____

Signature of the Declarant : _____

(On behalf of all the Proposed to be Insured under the Policy)

Acknowledgement for Proposal

Please retain this counterfoil for your records

(On behalf of Care Health Insurance Limited)

We acknowledge the receipt of payment of ₹_____ vide Cheque/DD No._____ from M/S._____Please note that this is only an acknowledgement receipt and does not amount to acceptance of risk or commencement of policy. Care Health Insurance 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. IRDAI Registration No. 148

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Group Care 360° Plus - Annexure - I to Proposal Form - Enrollment Data (Illustrative)

Policyholder Name	Policyholder Identification No/Bank Account No.	Primary Insured Member ID	Insured Member/ Dependent Name	Address of Primary Insured Member	DOJ (DD/MM/YY)	Age & Date of Birth	Relationship with Primary Insured Member	Gender	Nominee	Do you have ABHA No. ? If Yes, please mention

Section A : Medical Declaration

Part A

Please consider the following questions as they apply to each of the Member	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Have you or any of the persons proposed for insurance suffered from any of the following disease and/or have undergone treatment in a hospital for these disease / for any	Y N	Y N	Y N	Y N	Y N
Details	Existing Since_____	Existing Since_____	Existing Since_____	Existing Since_____	Existing Since_____
1. Cancer / tumor	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
2. Brain / Nervous System Disorders (For example: Stroke, Paralysis, Dementia, Epilepsy, Multiple Sclerosis, Psychiatric	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
3. Heart disease (For example: Coronary Artery Disease, Hypertension, Valve disease, Chest Pain, Heart Failure or	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
4. Chronic Lung Disease (For example: Asthma, COPD, Tuberculosis, Bronchitis, Emphysema, Pleural Effusion)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
5. Chronic Liver/Gastrointestinal Disease (For Example: Cirrhosis, Hepatitis, Pancreatitis, other Liver disease, Crohn's disease, Ulcerative Colitis, Piles)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
6. Diabetes with complications / or on Insulin (For example: Kidney Disease, Eye Disease, Foot Ulcer, Neuropathy)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
7. Chronic Kidney Disease (For example: Kidney Stones/ Renal Failure/ Dialysis/ CKD / Nephritis)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
8. Blood Disorders/ Auto-Immune Diseases Thalassemia Major (For example: Anemia, Bleeding Disorders, Immune - Endocrine/ Muscular/Neuro-Muscular/Bone Diseases (For Example: Thyroid, Pituitary, Muscular Dystrophies, Arthritis, Myasthenia Gravis)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
9. Endocrine/ Muscular/Neuro-Muscular/Bone Diseases (For Example: Thyroid, Pituitary, Muscular Dystrophies, Arthritis, Myasthenia Gravis)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
10. Disease of Reproductive and Urinary system (For example: Fibroids, Breast lumps, Hernia, Hydrocele, Menorrhagia, Prostate disorders)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
11. Others (please Specify)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____

SAMPLE

12. Has anyone been diagnosed / hospitalized or under any treatment for any illness / injury in the past? If yes, please specify details	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
13. Is anyone of the Insured's family member (I st blood relationship) is suffering from any genetic disorders	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____

Note: The Company shall reject 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.

Part B

This part applies if indicated 'Yes' in Part A replies. Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply.

Name of patient	Relevant section of Part A	Nature of illness/disability and treatment received	When did it start	How long did it last	Need for any further treatment or consultation	Present state of health in this respect

Signature of the Primary Insured Member : _____

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

Section B : (Corporate Declaration)

Questions to be completed by the Applicant's Authorized Personnel for all the persons (employees and dependents, if applicable) to be insured:

Note: If any of the answer is 'Yes', each concerned person(s) will have to go through a personal health declaration and any declared medical conditions will be subject to an underwriting decision.

1. Based on your company employee leave records, in the past two (2) years, has any person to be insured been:
   - On sick leave or hospital leave for five (5) consecutive days or more; or
   - On hospital leave for 2 times or more
2. Is any person to be insured currently hospitalized or been told that any medical treatment that is likely to result in an inpatient stay in the hospital or surgery, is required?
3. During the past two (2) years, has any person to be insured been diagnosed with, or under treatment, or investigation or follow up for any of the following condition:
   a) Cardiovascular Diseases: Include coronary artery disease, myocardial infarction, aortic aneurysm, heart failure, cardiac arrhythmia, heart valvular disease, ischemic heart disease.
   b) Neurological Conditions: Include stroke, brain aneurysm, Alzheimer's disease, Parkinson's disease, Syringomyelia, Multiple sclerosis, schizophrenia, epilepsy, Motor neuron disease;
   c) Hematologic disease: Include leukemia, lymphoma, aplastic anemia, Thrombocytopenic purpura, hemophilia
   d) Respiratory System: Include chronic obstructive pulmonary disease, primary pulmonary hypertension; pulmonary tuberculosis
   e) Digestive System: Include liver or hepatic cirrhosis, severe hepatitis such as but not limited to Hepatitis B, Hepatitis C.
   f) Urinary System: Include nephrotic syndrome, renal failure, renal dialysis
   g) Autoimmune Disease include: systemic lupus erythematosus, systemic scleroderma, AIDS
   h) Others: Include all malignant tumor, brain tumour, major organ failure/transplant, diabetes and complication, mental illness and drug alcohol problem.
4. During the last 6 months has any person to be insured or been advised by a doctor or a health professional or an alternative practitioner to take, or taking, any repeat medication or injections, whether prescribed or not, for at least 3 times a week and for a minimum period of 3 weeks or had in aggregate 4 or more visits to a doctor or a health professional?

   (This would exclude visits for 'malaria, dengue fever, typhoid, accidental injuries' where the person to be insured has been fully discharged by the doctor and he/she does not require any follow up consultation or further diagnostic/laboratory tests. For female to be insured- this would exclude normal childbirth where there is/had not been any complication in pregnancy and childbirth. This would exclude vitamins, food and health supplements and anti-oxidants)

Signature of the Authorized Personnel : _____

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

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Group Care 360° Plus - Annexure - II (Coverage Opted for – Base Benefit / Additional Benefit)

Coverage opted (✓)	S. No.	Name of Base Benefit / Additional Benefit	Special Terms & Conditions	Coverage Amount	Co-payment	Deductible	Franchise Deductible
		Base Benefits under 'Hospitalization Expenses'					
	1.	Base Benefit 1 : Hospitalization Expenses					
		a) In-Patient Care					
		b) Day care Treatment					
	2.	Base Benefit 2 : Well Baby & Well Mother Expenses					
	3.	Base Benefit 3 : Bereavement Cover					
	4.	Base Benefit 4 : Behavioral Cover					
	5.	Base Benefit 5 :Gender Reassignment Surgery					
	6.	Base Benefit 6 : Sleep Apnoea Treatment					
	7.	Base Benefit 7 : Sterilization					
	8.	Base Benefit 8 : Reasonable & Customary Charges Waive off					
	9.	Base Benefit 9 : Stem Cell / Umbilical Cord Preservation					
	10.	Base Benefit 10 : Home Care Treatment					
	11.	Base Benefit 11 : Vector Borne Disease cover					
	12.	Base Benefit 12 : Organ Transportation					
	13.	Base Benefit 13 : Wig cover					
	14.	Base Benefit 14 : Transportation of Imported Medicines					
	15.	Base Benefit 15 : Terminal Illness					
	16.	Base Benefit 16 : Loss of Pay due to Illness					
	17.	Base Benefit 17 : Emergency Illness cover					
		Base Benefit under Out-Patient Expenses					
	18.	Base Benefit 18 : Behavioral Disorders					
	19.	Base Benefit 19 : Hormone Replacement Therapy					
	20.	Base Benefit 20 : Oral Chemotherapy					
	21.	Base Benefit 21 : Sleep Apnoea					
	22.	Base Benefit 22: Vaccination for Adults					
	23.	Base Benefit 23 : Rehabilitation					
	24.	Base Benefit 24 : Embryo/Egg Freezing					
	25.	Base Benefit 25: Insect/Reptile /Animal bite					
	26.	Base Benefit 26: Daily Cash Allowance					
	27.	Base Benefit 27: ICU Cash					
		Base Benefit under Convalescence Benefit					
	28.	Base Benefit 28: Convalescence Benefit					
		Base Benefit under Personal Accident Cover					
	29.	Base Benefit 29: Common Disaster Benefit					
	30.	Base Benefit 30: Coma					
	31.	Base Benefit 31: Medical Extension					
	32.	Base Benefit 32: Mis hap Cover					
		Base Benefit under Critical Illness Fixed Benefit					
	33.	Base Benefit 33: Modification of Survival Period					
	34.	Base Benefit 34: Modification of Initial Wait Period					
	35.	Base Benefit 35: Critical Illness Fixed Benefit Modification					
		Additional Benefits					
	36.	Base Benefit 36: Assisted Reproductive Treatment					
	37.	Base Benefit 37: Assisted Reproductive Treatment Complications					
	38.	Base Benefit 38: Repatriation of Mortal Remains					
	39.	Base Benefit 39: Companion Benefit					
	40.	Base Benefit 40: Mortuary charges					
	41.	Base Benefit 41: Emergency Room Visit					
	42.	Base Benefit 42: Blood Purchase					
	43.	Base Benefit 43: Advance Ambulance Expenses					
	44.	Base Benefit 44: Be-fit Benefit					
	45.	Base Benefit 45: Digital- fit benefit					
	46.	Base Benefit 46: Fitness Equipment					
	47.	Base Benefit 47: Vector Borne Disease					
	48.	Base Benefit 48: Reducing Sum Insured Method					
	49.	Base Benefit 49: Non-payable items cover					

Note: The above list may vary depending upon the Benefits opted by the Group Administrator (Policyholder).

SAMPLE

Appendix I

For Companies	
Name of the company Principal place of business Mailing address of the company Telephone/Fax Number	(I) Certificate of incorporation and Memorandum & Articles of Association (II) Resolution of the Board of Directors to open an account and identification of those who have authority to operate the account (III) Power of Attorney granted to its managers, officers or employees to transact business on its behalf (IV) Copy of the telephone bill (V) Copy of PAN allotment letter
For Partnership firms	
Legal name Address Names of all partners and their addresses Telephone numbers of the firm and partners	(I) Registration certificate, if registered (II) Partnership deed (III) Power of Attorney granted to a partner or an employee of the firm to transact business on its behalf (iv) Any officially valid document identifying the partners and the persons holding the Power of Attorney and their addresses (v) Telephone bill in the name of firm/partners
For Trusts & Foundations	
Names of trustees, settlers, beneficiaries and signatories Names and addresses of the founder, the managers/directors and the beneficiaries Telephone/fax numbers	(I) Certificate of registration, if registered (II) Power of Attorney granted to transact business on its behalf (III) Any officially valid document to identify the trustees, settlors, beneficiaries and those holding Power of Attorney, founders/managers/ directors and their addresses (iv) Resolution of the managing body of the foundation/association (v) Telephone bill