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RELIGARE Values that bind | Health Insurance

Ab Health Hamesha

Proposal Form

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URN : RHICL / R / CI / 043 / 19-20

Proposal No.:_____

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.

FOR OFFICE USE ONLY

Intermediary Details

Intermediary Code :		Intermediary Name :	
Intermediary RM Code :		Branch Code :	
Loan Account No. :		Loan Tenure :	years

Religare Health Branch Details

RHIL RM Name :			
Branch Code :		Client ID :	Rec[illegible] :

Details of 'Point of Sales' Person : (To be filled in if the Policy is sourced through 'Point of Sales' Person)

Please furnish at least one of the following details of "Point of Sales" Person:	
Aadhar Card No.:	PAN C[illegible] No.:

PROPOSER DETAILS

Name : (Mr./Ms./Mrs.)	
	(First Name) (Middle Name) (Last Name)
Key Person Name : (Mr./Ms./Mrs.)	
	(First Name) (Middle Name) (Last Name)
Correspondence Address :	
Locality :	City :
Pin Code :	State :
Landmark :	
Permanent Address : If same as above, please tick here ☐	
Locality :	City :
Pin Code :	State :
Telephone :	Mobile :
Alternate No. :	
Email :	

Date of Birth / Incorporation (in case Proposer is an entity) : D D M M Y Y Y Y Gender : Male ☐ Female ☐ Others ☐

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

PAN Number :	Nationality :
Form 60 (in case the customer does not have PAN no.) : ☐ Yes ☐ No	Aadhaar Number : (By signing the Proposal form I give my consent for using my Aadhaar No. for Authentication of my Aadhaar Details)
Mother's Name :	

Would you like to opt for Electronic Policy Issuance through an e-Insurance Account (eIA) of an Insurance Repository? Yes ☐ No ☐

If you have an eIA, please provide following details:

I) Name of Insurance Repository :	
ii) eIA No :	
iii) Name as appearing in eIA :	

If you do not have an eIA, would you like to open an account? Yes ☐ No ☐

If Yes, choose any one Insurance Repository:

☐ NDML – NSDL Data Management Limited	☐ CAMSRep- CAMS Repository Services Limited
☐ Karvy Insurance Repository Limited	☐ CIRL-Central Insurance Repository Limited (CDSL)

Help us preserve the environment by opting to receive policy related information in soft copy/via email only : ☐ Yes ☐ No

Would you like to Subscribe to important alert on Whatsapp? ☐ Yes ☐ No

Religare Health Insurance Company Limited
Registered Office: 5th Floor, 19 Chawla House,Nehru Place,New Delhi-110019 Corresp. Office: Unit No. 604 - 607, 6th Floor, Tower C, Unitech Cyber Park, Sector-39, Gurugram -122001 (Haryana)
Website: www.religarehealthinsurance.com E-mail: customerfirst@religarehealthinsurance.com Call us: 1800-102-4488 | 1860-500-4488
CIN: U66000DL2007PLC161503 UIN: IRDA/NL-HLT/RHI/P-H(C)/V.I/14/13-14 IRDA Registration No. - 148

POLICY DETAILS

Proposed Policy Period Start Date :	D D M M Y Y Y Y	Plan :	
Sum Insured (in Rs.) :		Tenure :	1 Year ☐ 2 Year ☐ 3 Year ☐
Everyday Care Add-on Benefit :	Yes ☐ No ☐		
HIV Cover Add-on Benefit :	Yes ☐ No ☐		
Are you applying for portability?	Yes ☐ No ☐	(If yes, please fill in the separate Portability Form)	

NOMINEE DETAILS

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

*If the Nominee is of Age 18 years or less, Name of Appointee and Relationship with Minor:

Appointee Name	Date of Birth (DD/MM/YYYY)	Relationship with Minor

In event of the death of the Proposer any payment due under the Policy shall become payable to the Nominee proposed in this Proposal Form. The receipt of the proceeds by the Nominee would be sufficient discharge of the Company. The Nominee for all the other person(s) proposed to be insured shall be the Proposer himself.

DETAILS OF THE PROPOSED TO BE INSURED INCLUDING PROPOSER

Insured 1 : Name : Mr./Ms./Mrs.			
Marital Status	Date of Birth D D M M Y Y Y Y	Annual Income **(₹)** :	
Gender Male ☐ Female ☐ Others ☐	Aadhaar No. (Optional)		If PEP* : Yes ☐ No ☐
Relationship with Proposer :	Address :		Occupation : Self employed ☐ Service ☐
Insured 2 : Name : Mr./Ms./Mrs.			
Marital Status	Date of Birth D D M M Y Y Y Y	Annual Income **(₹)** :	
Gender Male ☐ Female ☐ Others ☐	Aadhaar No. (Optional)		If PEP* : Yes ☐ No ☐
Relationship with Proposer :	Address :		Occupation : Self employed ☐ Service ☐

*Have you ever been entrusted with prominent public functions, for example, Heads of State or of Government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations or important political party officials.

Please fill the following details :

Details	Insured 1	Insured 2
Have you ever been diagnosed/suffered/treated/taken medication for any disease, illness, injury or condition? If yes, Please provide details in **Annexure – 1** to this Proposal	Y N	Y N
Have ever you applied for or are you covered under any health insurance policy(ies) with this company or any other insurance companies? If yes, Please provide details in **Annexure – 2** to this Proposal	Y N	Y N
Do you smoke or consume gutkha / pan masala or alcohol?	Y N	Y N
If yes please indicate the name and quantity per week.		

MEDICAL & LIFE STYLE 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 in "Yes" or "No" unless other options are provided.

S.No.	Particulars	Insured 1	Insured 2
1.	Are you now in good health and entirely free from any mental or physical impairments or deformities?		
2.	Height	Height (Cms.) _____	Height (Cms.) _____
3.	Weight	Weight (Kg.) _____	Weight (Kg.) _____
4.	How much weight have you lost or gained over the last 12 months? _____(Kg.)		
	Reason for weight change		
5.	Have you been hospitalised for treatment of an illness or injury? If yes, please provide details in **Annexure** to this Proposal	Y N	Y N
6.	Have you been aware or told you have the following :		
	1. Heart Diseases	Y N	Y N
	2. Kidney / Lung / Liver Disease	Y N	Y N
	3. Cancer	Y N	Y N
	4. Diabetes	Y N	Y N
	5. High Blood	Y N	Y N
7.	Have you been told that you are required for an impending hospital/surgical treatment? If Yes, please provide information in a separate sheet	Y N	Y N

Please fill in the **Annexure -4, Annexure -5** to this Proposal in case you are applying for other than for protection of your financial liability.

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, Company shall cancel your proposal and refund the premium amount after deducting cost of medical tests, if any.

ATTENDING PHYSICIAN'S DETAILS

Name of Family Physician :			
	(First Name)	(Middle Name)	(Last Name)
Contact Number :		Email :	

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 insured / 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.

Date : / / (DD/MM/YYYY)

Place :

Signature of the Proposer :

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

NEFT DETAILS (FOR CLAIMS & REFUND PURPOSES)

Account Number :	IFSC Code :
Bank Name :	Bank Branch Name :
Name of the Account Holder :	

Note : Please submit copy of cancelled cheque along with Proposal Form

I declare that the information given above is true and correct. I hereby authorize Religare Health Insurance Company Limited to directly credit payout / refund, if any, to the above mentioned account and I shall not hold Religare Health Insurance Company Limited responsible for non-credit/non-payment of payout or refund, if any, due to any reason including but not limited to incorrect / incomplete information. Religare Health Insurance Company Limited reserves right to use any alternative payout option such as cheque/demand draft in spite of providing above information.

Date : / / (DD/MM/YYYY)

Place :

Signature of the Proposer

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

PAYMENT INFORMATION

Premium Amount (₹) :	
Payment By Cash / Cheque / Demand Draft / Card (Strike out whichever is not applicable) :	
Cheque / Demand Draft No. / Authorization ID :	
Mode :	☐ Single ☐ Annual ☐ Half-yearly ☐ Quarterly

* Not applicable for 1 year tenure

Date :	Amount (₹) :
Bank Name :	

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

Note: Should you choose to pay premium by cash, you are advised to do so only at the nearest Religare health insurance company limited branch or any authorized Bank branch, and we insist you to please ask for computerize receipt against the deposited cash against your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.

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.

DECLARATION FOR AGENTS

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), 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, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable as per Policy Terms and Conditions 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 : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Signature : _____

SP Name : _____

SP Code : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ANNEXURE - 1 DETAILS OF PERSONAL MEDICAL HISTORY

Details	Insured 1	Insured 2
Month and year when such Illness, disease, injury or condition was first detected	Y N	Y N
Treatment(s) taken for the same along with duration for which the treatment(s) medication was taken	Y N	Y N
Additional details if any	Y N	Y N

ANNEXURE - 2 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 To		
Sum Insured (in Rs.)		
Have any of the persons to be insured ever filed a claim with their current/ previous insurer? Yes, please provide details on a separate sheet	Y N	Y N
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	Y N	Y N
Is any of the persons proposed for insurance covered under any other health insurance policy with the Company?	Y N	Y N

ANNEXURE - 3 DETAILS FOR HOSPITALIZATION

DATE OF HOSPITALIZATION	DIAGNOSIS

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 Cash/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 the Policy. The Company is not liable for any claim between the time that the proposal amount is received and Policy Start Date. The validity of this receipt is subject to realization of the proposal amount. Acceptance of proposal and issuance of the Policy shall be subject to receipt of the completed Proposal Form, premium payment, medical reports (wherever applicable) and underwriting decision of the Company.

Proposal No.: _____

Signature of the Representative : _____

Name of the Representative : _____

Insurance is a subject matter of solicitation. IRDA Registration No. 148

Note: Should you choose to pay premium by cash, you are advised to do so only at the nearest Religare Health insurance company limited branch or any authorized Bank branch, and we insist you to please ask for computerize receipt against the deposited cash against your Proposal. Any claim without computerized receipt against the deposited cash will not be admitted.

ANNEXURE - 4 HEALTH QUESTIONNARIE

S.No.	Details	Insured 1	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)?	Y N	Y N
	Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia or emphysema)?	Y N	Y N
	Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)?	Y N	Y N
	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)?	Y N	Y N
	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)?	Y N	Y N
	Diabetes mellitus, cancer or tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes or skin?	Y N	Y N
	Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands?	Y N	Y N
	Liver disease	Y N	Y N
	Lung disease	Y N	Y N
	Chronic Relapsing Pancreatitis	Y N	Y N
	Any other diseases or ailments not mentioned above?	Y N	Y N
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?	Y N	Y N
3.	Have you ever had or been advised to have hospital treatment or surgery?	Y N	Y N
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?	Y N	Y N
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?	Y N	Y N
6.	Have you ever received or do you now receive any personal accident disability benefit, or disability-related payments?	Y N	Y N
7.	Are you at present or any time in past were on any medication, special diet, or treatment?	Y N	Y N
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?	Y N	Y N
9.	Do you participate or do you intend to participate in any hazardous sports or activities such as motor sports, climbing, parachuting, hang-gliding, or aviation except as a fare-paying passenger?	Y N	Y N
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?	Y N	Y N

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 the reverse of this form and duly self-certified by you and the date.

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Signature of the Proposer :_____

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

ANNEXURE - 5 OCCUPATION CATEGORIES

Details	Insured 1	Insured 2
Under which of the following categories does your occupation fall?		
• Employees without exposure to manual work outside Office (Admin/Finance and Accounting/Sales & Marketing/BPO/IT/Actuaries/Audit/Operations/HR/R&D)	☐	☐
• Professionals without exposure to manual work outside Office (Academicians/Healthcare/Legal/ Consultants/ Architects/Engineers/Real E	☐	☐
• Technicians (other than except Heavy Machinery Operators/Electrician/Nuclear and chemical Lab Technician)	☐	☐
• Business owners (Excluding Chemical, Arms and Ammunitions, Explosives, Fireworks)	☐	☐
• Please specify occupation if not in the above categories	_____	_____

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) Signature of the Proposer :_____

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