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RELIGARE Values that bind | Health Insurance

Ab Health Hamesha

Proposal Form

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URN : RHICL / R / HE / 002 / 16-17

Proposal No.:_____

1. To be filled in by the 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. 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".

FOR OFFICE USE ONLY

Intermediary Details

Intermediary Code :		Intermediary Name :	
Intermediary RM Code :		Branch Code :	
Customer Acc No. :			

Religare Health Branch Details

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

PROPOSER DETAILS

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 :
Email :	

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

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

PAN Number : (PAN Mandatory for premium above Rs. 49,999)	Nationality :
Mother's Name :	

Would you like to opt for Electronic Policy Issuance through an 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 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 – NDML Management Limited	☐ CAMSRep- CAMS Repository Services Limited
☐ Karvy Insurance Repository Limited	☐ CIRL-Central Insurance Repository Limited (CDSL)

POLICY DETAILS

Plan Opted :			
Sum Insured (in Rs.) :		Tenure :	1 Year ☐ 2 Year ☐ 3 Year ☐
Deductible (in Rs.) :		Co-payment (in %) :	
Cover Type :	Individual ☐ Floater ☐		
Optional Cover – 1 : Good Health+	Yes ☐ No ☐		
(If Yes, then please mention the per consultation payable claim limit (in Rs.) :			
Optional Cover – 2 : Home Care	Yes ☐ No ☐		
Optional Cover – 3 : Health Check+	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)	

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.

Height cms | Marital Status | Date of Birth D D M M Y Y Y Y | Annual Income (In Lacs) : ₹

Weight kg | Gender Male ☐ Female ☐ | Aadhaar No. | Nominee (Relationship with Insured) :

Relationship with Proposer : | City of Residence : | If PEP* : Yes ☐ No ☐

Insured 2 : Name : Mr./Ms./Mrs.

Height cms | Marital Status | Date of Birth D D M M Y Y Y Y | Annual Income (In Lacs) : ₹

Weight kg | Gender Male ☐ Female ☐ | Aadhaar No. | Nominee (Relationship with Insured) :

Relationship with Proposer : | City of Residence : | If PEP* : Yes ☐ No ☐

Insured 3 : Name : Mr./Ms./Mrs.

Height cms | Marital Status | Date of Birth D D M M Y Y Y Y | Annual Income (In Lacs) : ₹

Weight kg | Gender Male ☐ Female ☐ | Aadhaar No. | Nominee (Relationship with Insured) :

Relationship with Proposer : | City of Residence : | If PEP* : Yes ☐ No ☐

Insured 4 : Name : Mr./Ms./Mrs.

Height cms | Marital Status | Date of Birth D D M M Y Y Y Y | Annual Income (In Lacs) : ₹

Weight kg | Gender Male ☐ Female ☐ | Aadhaar No. | Nominee (Relationship with Insured) :

Relationship with Proposer : | City of Residence : | If PEP* : Yes ☐ No ☐

Insured 5 : Name : Mr./Ms./Mrs.

Height cms | Marital Status | Date of Birth D D M M Y Y Y Y | Annual Income (In Lacs) : ₹

Weight kg | Gender Male ☐ Female ☐ | Aadhaar No. | Nominee (Relationship with Insured) :

Relationship with Proposer : | City of Residence : | If PEP* : Yes ☐ No ☐

Insured 6 : Name : Mr./Ms./Mrs.

Height cms | Marital Status | Date of Birth D D M M Y Y Y Y | Annual Income (In Lacs) : ₹

Weight kg | Gender Male ☐ Female ☐ | Aadhaar No. | Nominee (Relationship with Insured) :

Relationship with Proposer : | City of Residence : | If PEP* : Yes ☐ No ☐

*Have you ever been entrusted with prominent public functions, i.e. 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.

MEDICAL / LIFESTYLE RELATED INFORMATION

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Does any proposed insured currently or in past Diagnosed/Suffered/Treated/Taken Medication for any of following conditions: If yes, please provide details in the additional information section below:						
1. Cancer, tumour, polyp or cyst	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
2. Any heart disease or disorder, chest pain or discomfort, irregular heart beats, palpitations or heart murmur	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
3. Hypertension / Blood Pressure(BP) / High Cholestrol	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
4. Asthma / Tuberculosis (TB) / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
5. Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pituitary tumor/ disease or any other disorder of Endocrine system?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
7. Motor Neuron Disease/ Muscular dystrophies/ Myasthnia Gravis or any other disease of Neuromuscular system (muscles and/or nervous system)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
8. Stroke/ Paralysis/ Transient Ischemic Attack/ Multiple Sclerosis/ Epilepsy/ Mental-Psychiatric illness/ Parkinsonism/ Alzeihmer's/ Depression / Dementia or any other disease of Brain and Nervous System?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
9. Cirrhosis / Hepatitis / Wilson's disease / Pancreatitis / Liver disease / Crohn's disease / Ulcerative Colitis /Piles or any other disease of Mouth, Esophagus, Liver, Gall bladder, Stomach or Intestines or any other part of Digestive System?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____

10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
11. HIV/SLE/ Arthiritis/ Scleroderma / Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin.	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
12. Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses)?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
13. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please provide the frequency & amount consumed	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
14. Any other disease / health adversity / injury/ condition / treatment not mentioned above?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
15. Has any of the Proposed to be Insured been hospitalized/recommended to take investigations/medication or has been under any prolonged treatment/ undergone surgery for any illness/injury other than for childbirth/minor injuries?	Y N Since_____	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.

ADDITIONAL INFORMATION (IF YOUR ANSWER IS 'YES' TO ANY OF THE ABOVE QUESTION OR THE PROPOSED TO BE INSURED ARE SUFFERING FROM ANY OTHER PRE EXISITNG DISEASE WHICH IS NOT MENTIONED IN THE ABOVE LIST)

DETAILS OF PREVIOUS OR EXISTING HEALTH INSURANCE

Please fill the following details with respect to health insurance proposals/policies with the Company or any other insurance companies

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Have any of the person(s) to be insured ever filed a claim with their current/previous insurer? If Yes, please provide details on a separate sheet	Y N	Y N	Y N	Y N	Y N	Y N
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	Y N	Y N	Y N	Y N	Y N	Y N
Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company?	Y N	Y N	Y N	Y N	Y N	Y N

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 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 life 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 claim 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)

Signature of the Proposer :_____

Place :

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

PREMIUM PAYMENT INFORMATION

Payment By Cash / Cheque / Demand Draft / Card (Strike out whichever is not applicable) :			
Cheque / Demand Draft No. / Authorization ID :			
Payment Amount (₹) :		Premium Amount (₹) :	
Date :		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 alc[illegible]or drug use, misuse or abuse / Cost of spectacles[illegible]tact lense[illegible]ental treatment / Medical expenses incurred for treatment of AIDS / Treatment arising from or traceable to pregnancy and childbirth, miscarriage, abortion and its consequen[illegible]relating to infertility and in vitro fertilization / Con[illegible]al d[illegible]se.
(v) Treatment/consultation in a hospital which is named in the negative list of hospitals.

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

Note: Should you choose to pay premium by cash, you are advised to do so only at the nearest Religare Health insurance company li[illegible]any authori[illegible]ank branch, and we insist you to pleas[illegible]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[illegible]or renew or conti[illegible]n insuran[illegible]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 [illegible]ving or continuing [illegible]cy [illegible]ept 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 wh[illegible]may e[illegible]d to ten lakh rupees.

DECLARATION FOR AGENTS

I _____ (Full Name) in my capacity as an Insurance Advisor/[illegible]cified Person o[illegible]Corporate Agent/ A[illegible]rized 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 t[illegible]Proposer including [illegible]ment(s), informatio[illegible]d 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 [illegible]Proposer, if this pro[illegible]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/[illegible]ndum(s), affidavits, s[illegible]ments, submissions, furn[illegible]/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 o[illegible]his/her favor pursuant to th[illegible]posal 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 :

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.