

Proposal Form



URN : RHICL / R / HE / 038 / 19-20

Proposal No.: _____

- To be filled in by the Proposer in CAPITAL LETTERS only.
- 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.
- 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.
- 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 :	Client ID :	Receipt ID :
Branch Code :		

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 Card No.:
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PROPOSER DETAILS

Name : (Mr./Ms./Mrs.)	(First Name)	(Middle Name)	(Last Name)
Correspondence Address :			
Locality :	State :	City :	
Pin Code :			
Landmark :			
Permanent Address : <input type="checkbox"/>	If same as above, please tick here		
Locality :	State :	City :	
Pin Code :			
Telephone :		Mobile :	
Alternate Number :			
Email :			

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

D	D	M	M	Y	Y	Y	Y
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 Gender : Male Female Others

Marital Status : Single Married Divorced Widow(er) Separated

PAN Number : _____ Nationality : _____

Form 60 (or 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) eIAno : _____

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:

<input type="checkbox"/> NDML – NSDL Data Management Limited	<input type="checkbox"/> CAMSRep- CAMS Repository Services Limited
<input type="checkbox"/> Karvy Insurance Repository Limited	<input type="checkbox"/> 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

POLICY DETAILS

Plan Opted:												
Sum Insured (in Rs.):							Tenure:	1 Year <input type="checkbox"/>	2 Year <input type="checkbox"/>	3 Year <input type="checkbox"/>		
Deductible (in Rs.):							Co-payment (in %):					
Cover Type:	Individual <input type="checkbox"/>	Floater <input type="checkbox"/>										
Optional Cover – 1 : Good Health+	Yes <input type="checkbox"/>	No <input type="checkbox"/>										
(If Yes, then please mention the per consultation payable claim limit (in Rs.):												
Optional Cover – 2: Home Care	Yes <input type="checkbox"/>	No <input type="checkbox"/>										
Optional Cover – 3: Health Check+	Yes <input type="checkbox"/>	No <input type="checkbox"/>										
(If Yes, then please tick which one:	Diabetes Health Check-up <input type="checkbox"/>	Cardiac Health Check-up <input type="checkbox"/>										
Are you applying for portability?	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(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 shall 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			DD	MM	YY	YY	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>	Aadhaar No.					
Nominee (Relationship with Insured) :			Relationship with Proposer :			City of Residence :			If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>		
Insured 2 : Name : Mr./Ms./Mrs.											
Height	cms	Marital Status	Date of Birth			DD	MM	YY	YY	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>	Aadhaar No.					
Nominee (Relationship with Insured) :			Relationship with Proposer :			City of Residence :			If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>		
Insured 3 : Name : Mr./Ms./Mrs.											
Height	cms	Marital Status	Date of Birth			DD	MM	YY	YY	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>	Aadhaar No.					
Nominee (Relationship with Insured) :			Relationship with Proposer :			City of Residence :			If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>		
Insured 4 : Name : Mr./Ms./Mrs.											
Height	cms	Marital Status	Date of Birth			DD	MM	YY	YY	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>	Aadhaar No.					
Nominee (Relationship with Insured) :			Relationship with Proposer :			City of Residence :			If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>		
Insured 5 : Name : Mr./Ms./Mrs.											
Height	cms	Marital Status	Date of Birth			DD	MM	YY	YY	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>	Aadhaar No.					
Nominee (Relationship with Insured) :			Relationship with Proposer :			City of Residence :			If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>		
Insured 6 : Name : Mr./Ms./Mrs.											
Height	cms	Marital Status	Date of Birth			DD	MM	YY	YY	Annual Income (In Lacs) :	₹
Weight	kg	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Others <input type="checkbox"/>	Aadhaar No.					
Nominee (Relationship with Insured) :			Relationship with Proposer :			City of Residence :			If PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>		

*Have you ever been in contact 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.

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 the following conditions: If yes, please provide details in the additional information section below:						
1. Cancer; tumor; polyp or cyst	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____
2. Any heart disease or disorder; chest pain or discomfort; irregular heart beats; palpitations or heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____
3. Hypertension / High Blood Pressure(BP)/ High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____

4. Asthma / Tuberculosis (TB) / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
5. Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pituitary tumor/ disease or any other disorder of Endocrine system?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
7. Motor Neuron Disease/ Muscular dystrophies/ Myasthnia Gravis or any other disease of Neuromuscular system (muscles and/or nervous system)	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
8. Stroke/ Paralysis/ Transient Ischemic Attack/ Multiple Sclerosis/ Epilepsy/ Mental-Psychiatric illness/ Parkinsonism/ Alzheimer's/ Depression / Dementia or any other disease of Brain and Nervous System?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
10. Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
11. HIV/SLE/ Arthritis/ Scleroderma / Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin.	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
12. Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses)?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
13. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please indicate the following: - Hard Liquor (No. of Pegs in 30 ml per week) - Beer(Bottles/ml per week) - Wine(Glasses/ml per week) - Smoking (no. of Sticks per day) - Gutka/Pan Masala/Chewing Tobacco(Sachets/Grams per day)	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____
14. Any other disease / health adversity / injury/ condition / treatment not mentioned above?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____

Note: The Company shall reject Your proposal and refund the premium amount (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 QUESTIONS OR THE PROPOSED TO BE INSURED ARE SUFFERING FROM ANY OTHER PRE-EXISTING 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	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Has any of your proposal(s) for health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company or any other Company without break?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____ (DD/MM/YYYY)	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____ (DD/MM/YYYY)

Religare Health Insurance Company Limited

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 :

SAMPLE