Domestic Staff Insurance

RELIGARE Values that bind | Health Insurance

Ab Health Hamesha

Proposal Form

URN : RHICL / R / HE / 48 / 19-20

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 "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 :	Agent ID :

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.:	

PROPOSER DETAILS

Name : (Mr./Ms./Mrs.)			
	(First Name)	(Middle Name)	(Last Name)
Proposer Insurance details with RHI :	Name of Base Product : _____	Base Policy Number:	
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 : Married ☐ Divorced ☐ Widow(er) ☐ Separated ☐

PAN Number :		Nationality :	
Form 60 (only 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:

☐ CAMSRep – CAMS Insurance Repository & Services	☐ NDML – NSDL Data Management Limited
☐ SHCIL – Stock Holding Corporation of India Limited	☐ KARVY
☐ CIRL – Central Insurance Repository Limited	

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

Ver:July/19

POLICY DETAILS

Proposed Policy Period Start Date :	D D M M Y Y Y Y	Plan Opted :			
Sum Insured (in Rs.) :					
Cover Type :	☐ Individual	☐ Floater	Tenure :	☐ 1 Year ☐ 2 Year ☐ 3 Year	
Are you applying for portability?	☐ Yes	☐ No	(If yes, please fill in the separate Portability Form)		

NOMINEE DETAILS OF THE INSURED

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

*Only where the Nominee is of Age 18 years or less:

Appointee Name

In event of the death of the Insured any Payment shall become payable to the Nominee proposed for the Insured 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 Insured himself.

DETAILS OF THE PROPOSED TO BE INSURED

Insured 1 : Name : Mr./Ms./Mrs.					
Marital Status	Date of Birth D D M M Y Y Y Y	Height : cms	Weight : kg		
Gender ☐ Male ☐ Female ☐ Others	Aadhaar No. (Optional)		Annual Income (in Rs.):		
Relationship with Insured :	Address :				
Occupation type of Domestic Help :		Nominee (Relationship with Insured) :			
Insured 2 : Name : Mr./Ms./Mrs.					
Marital Status	Date of Birth D D M M Y Y Y Y	Height : cms	Weight : kg		
Gender ☐ Male ☐ Female ☐ Others	Aadhaar No. (Optional)		Annual Income (in Rs.):		
Relationship with Insured :	Address :				
Occupation type of Domestic Help :		Nominee (Relationship with Insured) :			
Insured 3 : Name : Mr./Ms./Mrs.					
Marital Status	Date of Birth D D M M Y Y Y Y	Height : cms	Weight : kg		
Gender ☐ Male ☐ Female ☐ Others	Aadhaar No. (Optional)		Annual Income (in Rs.):		
Relationship with Insured :	Address :				
Occupation type of Domestic Help :		Nominee (Relationship with Insured) :			
Insured 4 : Name : Mr./Ms./Mrs.					
Marital Status	Date of Birth D D M M Y Y Y Y	Height : cms	Weight : kg		
Gender ☐ Male ☐ Female ☐ Others	Aadhaar No. (Optional)		Annual Income (in Rs.):		
Relationship with Insured :	Address :				
Occupation type of Domestic Help :		Nominee (Relationship with Insured) :			

Please fill the following details :

Details	Insured 1	Insured 2	Insured 3	Insured 4
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	Y N	Y N	Y N	Y N
Does your job require you to be involved with any hazardous activity, significant manual labor, operating heavy machinery, handling hazardous material, working at height, underground / construction sites, oil rigging, high voltage, high temperature, working in ocean-going vessels or adventure sports or armed forces?	Y N	Y N	Y N	Y N

MEDICAL / LIFESTYLE RELATED INFORMATION

Particulars	Insured 1	Insured 2	Insured 3	Insured 4
Does any proposed insured currently 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	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, palpatations or heart murmur	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
3. Hypertension / High Blood Pressure(BP)/ High Cholestrol	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_____
5. Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pitutiary tumor/ disease or any other disorder of Endocrine system ?	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_____

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_____
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_____
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_____
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_____
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_____
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_____
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)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
14. Has any of the Proposed to be insured or his/her family member(1st blood relation) suffering from any of the following conditions: Down's Syndrome/Turner's Syndrome/Sickle Cell Anaemia/ Thalassemia Major/G6PD deficiency	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
15. Any other disease / health adversity / injury/ condition / treatment not mentioned above?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
16. 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_____

Note: The Company shall reject Your proposal and refund the premium amount (after deducting cost of medical test, 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 EXISITNG DISEASE WHICH IS NOT MENTIONED IN THE ABOVE LIST)

ATTENDING PHYSICIAN'S DETAILS

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

DETAILS OF PREVIOUS/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
Have any of the person(s) to be insured ever claimed a claim with their current/ previous insurer? If Yes, please provide details on a separate sheet.	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
Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company or any otherCompany without break?	Y N Since_____ (DD/MM/YYYY)	Y N Since_____ (DD/MM/YYYY)	Y N Since_____ (DD/MM/YYYY)	Y N Since_____ (DD/MM/YYYY)

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)

Bank account details of the Proposer (For Refund Purposes)

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

Bank account details of the Proposed to be Insured (For Re-imbursement Claims)

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 c fund, if ar e 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 li incor omplete ation. Religare Health rance 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 :

nature of the P

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

PREMIUM PAYMENT INFORMATION

Payment By Cash / Cheque / Demand Draft / Card (Strike out whichever is not applic e) :			
Cheque / Demand Draft No. / Authorization ID :			
Payment Amount (₹) :		remium A unt (₹)	
Date :		Bank Nar	

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

Key Exclusions :

(I) Any disease contracted during the first 30 days of the policy sta te, e e arising out of acc

(ii) 2 Year Wait Period : Non-infective arthritis/Joint replacement/C act/Piles/ nose and throa T) disorders and surgeries/Stones, etc.

(iii) Pre-existing Diseases : 48 months from the date of the first polic

(iv) Permanent Exclusions : Non-allopathic treatment / Expenses att able to self- esulting fr n suicide, attempted suicide) or alcohol or drug use, misuse or abuse / Cost of spectacles, contact lenses / dental treatment / Medical expenses incurred for treatment of AIDS / Treatment arising from aceable egnancy th, miscarriage, abortion and its consequences or relating to infertility and in vitro fertilization / Congenital disease.

(v) Treatment/consultation in a hos d in the negative of th is.

For a detailed set of exclusions, ple on to www. ligarehealthinsuranc

Note: Should you choose to pay um by cash, you are advised to do so o 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 Pro . Any claim without computerized receip st the deposited cash will not be admitted.

STATUTORY W NI

Prohibition of Rebates

(Under Section 41 of Insurance Act 1938)

1. No person shall allow or offer to allow, e r directly or dy, 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 t n 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)m 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 nondisclosure 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 : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ADDENDUM – VERNACULAR DECLARATION

I _____, son/daughter of _____, resident of _____ declare that I have 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.

License No. (Advisor/Corporate Agent/Broker/Relationship Officer):

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Signature of the declarant : _____

Place : _____

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

Name of the declarant : _____

EMPLOYER DECLARATION FORM

I _____ (Full Name) of _____ (Current Residential Address) hereby solemnly declare that I will be availing the services of the Domestic Help whose details are set out hereunder,

Name of the Domestic Help :	
Date of Birth / Incorporation (in case Proposer is an entity) :	D D M M Y Y Y Y Place of Birth :

Details of Identification proof like Adhar Card /Authorized I Card /Ration Card (if any) : _____

Current Residential Address : _____

Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Signature of the declarant : _____

Place : _____

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.