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RELIGARE Values that bind | Health Insurance

Ab Health Hamesha

Proposal Form

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URN : RHICL / R / TR / 006 / 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 or to issue a policy by mere submission of a completed proposal form and / or payment of proposal deposit towards the same. 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 :	
Customer Acc No. :			

Religare Health Branch Details

RHIL RM Name :			
Branch Code :		Client ID :	Receipt ID :

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 :
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 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)

POLICY DETAILS

Proposed Policy Period Start Date :	D D M M Y Y Y Y		Proposed Policy Period End Date :	D D M M Y Y Y Y	
Cover Type :	☐ Individual	☐ Family Option*	Trip Type :	☐	☐ ☐
Trip Type :	☐ Single Trip	☐ Annual Multi-trip (45 days)	☐ Annual Multi-trip (60 days)		
Purpose of travel :	☐ Business	☐ Adventure Sports	☐ Visit to Family / Friends	☐ Pleasure	☐ Aviation

Plan#	Sum Insured#	Geographical scope#	Opt for Sub-limits
☐ Explore Platinum	☐ $ 500,000 ☐ $ 300,000	☐ Worldwide (Excluding India)	N.A. (For plan without sub-limits refer "Explore – Platinum")
☐ Explore Gold	☐ $ 100,000 ☐ $ 50,000	☐ Worldwide (Excluding US, Canada and India)	N.A. (For plan with sub-limits refer "Explore – Gold")

Plan#	Sum Insured#	Geographical scope#	Opt for Sub-limits
☐ Explore Asia	☐ $ 100,000 ☐ $ 50,000 ☐ $ 25,000	☐ Asia (Excluding India)	Y N
☐ Explore Africa	☐ $ 100,000 ☐ $ 50,000 ☐ $ 25,000	☐ Africa	Y N
☐ Explore Canada+	☐ $ 100,000 ☐ $ 50,000	☐ Worldwide (Excluding US and India)	Y N
☐ Explore Europe	☐ € 100,000 ☐ € 30,000	☐ Europe	Y N

Choose any one Plan along with its corresponding Sum Insured and Geographical Scope.

*Valid relationship for Family Option : Self, Spouse, dependent children and Parents

Country(s) of visit: 1._____2._____3._____4._____5._____6._____

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 form. The receipt of the proceeds by the Nominee would be sufficient discharge to the company. Nominee for all the other person(s) proposed to be insured shall be the Proposer himself.

DETAILS OF THE PERSONS TO BE INSURED INCLUDING PROPOSER

Insured 1 : Name : Mr./Ms./Mrs.					
Marital Status		Date of Birth D D M M Y Y Y Y	Passport No. :		
Gender	Male ☐ Female ☐	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	Passport No. :		
Gender	Male ☐ Female ☐	Aadhaar No. (Optional)		If PEP* : Yes ☐ No ☐	
Relationship with Proposer :		Address :		Occupation : Self employed ☐	Service ☐
Insured 3 : Name : Mr./Ms./Mrs.					
Marital Status		Date of Birth D D M M Y Y Y Y	Passport No. :		
Gender	Male ☐ Female ☐	Aadhaar No. (Optional)		If PEP* : Yes ☐ No ☐	
Relationship with Proposer :		Address :		Occupation : Self employed ☐	Service ☐
Insured 4 : Name : Mr./Ms./Mrs.					
Marital Status		Date of Birth D D M M Y Y Y Y	Passport No. :		
Gender	Male ☐ Female ☐	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.

Note : Where the cover type is individual, the age for entry shall be minimum 1 day and maximum as per the plan.

Please fill the following details :

Details	Insured 1	Insured 2	Insured 3	Insured 4
Is any of the member proposed to be insured suffering from any illness or disease? If yes, Please provide details	Y N	Y N	Y N	Y N
Disease(s) : Cancer/ Tumor / Artery / Heart disease, Insulin Dependent Diabetes, Paralysis/ Stroke, Congenital Disease, HIV/ AIDS/ STD, Liver Disease, Kidney Disease, Thalassemia Major, Other (Please Specify)				
Month & Year when such Pre-existing Disease was first detected	M M Y Y	M M Y Y	M M Y Y	M M Y Y
Has anyone been diagnosed / hospitalized / under any treatment for any illness / injury during the last 48 months ? If yes, please specify details on separate sheet	Y N	Y N	Y N	Y N
Have you ever claimed under any travel policy? If yes, please give details under the section claimed.	Y N	Y N	Y N	Y N

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)

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)

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 :	
Sources of Funds :	☐ Salary ☐ Business ☐ Others	(if others, please specify) :	

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

Note: Attention is drawn to Sec 64VB of the insurance act by virtue of which the proposer is obliged to pay the premium in advance for acceptance the risk.
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 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 document(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/addendum(s), affidavits, statements, submissions, further 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 material fact by this/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 : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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.