CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai – 600 001.
Toll free: 1800 208 9100, T: +91 (0) 44 4044 5400, F: +91 (0) 44 4044 5550
E: customercare@cholams.murugappa.com; website: www.cholainsurance.com
IRDA Regn. No.123**; PAN** AABCC6633K **CIN** U66030TN2001PLC047977

Arogya Sanjeevani Policy, Chola MS
UIN: CHOHLIP20035V021920
PROPOSAL FORM
Proposal form URN: Chola MS-ASP-068-2020

POSP Name:	**POSP PAN:**

1. PROPOSER DETAILS

Name		
Date of Birth: DD/MM/YYYY	Gender: ☐ Male ☐ Female ☐ Transgender	Marital Status: ☐ Single ☐ Married ☐ Others
Occupation	☐ Salaried ☐ Self-Employed ☐Others, Please specify	
Annual Income:	GST No. (if applicable)	
PAN Card No.	Aadhaar No.	Passport No.
Address for Communication	City: State:	Pincode: ☐☐☐☐☐☐
Landline No. (with STD Code):	Mobile No.:	
E mail ID:		
Are you an Existing customer of Chola MS: ☐ Yes ☐ No	If yes, please provide the Policy no.	

2. DETAILS OF PERSONS TO BE INSURED

Sl. No.	**Name**	**Gender (M/F)**	**Date of Birth**	**Relationship with the proposer**	***Height (in Cms)**	***Weight (in Kgs)**	***Occupation**	**ABHA Number (14 digits)#**
			DD/MM/YYYY					

- In case you are opting for a Family Floater cover, please mention the Floater Sum Insured against the 1st Insured's Name
- Proposals for members above 50 years of age will be processed only with a medical check up
- *Mandatory fields #Ayushman Bharat Health Account

3. NOMINATION *(Nominee details are mandatory. We do not get any separate nomination form signed. In case the nominee is a minor, the appointee details will have to be provided)*

Nominee Name:	Relationship of the Nominee:	
Nominee DOB:	Nominee Mobile Number:	Email ID:
Nominee Present Address:		
Nominee Permanent Address:		
Name of Bank and Branch:		
A/c. No.:	IFSC Code:	MICR Code:

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Nominee mentioned above is for the proposer. For other members covered under the policy, Proposer is deemed to be the Nominee

Where Nominee is a minor, please give the details of Appointee

Name of the Appointee:	Relationship to Nominee:
Appointee Mobile number:	Email ID
Appointee Present Address:	
Appointee Permanent Address:	

4. COVERAGE DETAILS (please tick the option selected)

Policy Type: ☐ Individual ☐Family Floater | Policy Tenure: ☐ 1 Year ☐ 2 Years ☐ 3 Years

Sum Insured Options	☐ Rs.50,000/-	☐ Rs.1 Lakh	☐ Rs.1.50 Lakhs	☐ Rs.2 Lakhs	☐ Rs.2.5 Lakhs
	☐ Rs.3 Lakhs	☐ Rs.3.5 Lakhs	☐ Rs. 4 Lakhs	☐ Rs.4.5 Lakhs	☐ Rs.5 Lakhs
	☐ Rs.5.5 Lakhs	☐ Rs.6 Lakhs	☐ Rs.6.5 Lakhs	☐ Rs.7 Lakhs	☐ Rs.7.5 Lakhs
	☐ Rs.8 Lakhs	☐ Rs.8.5 Lakhs	☐ Rs.9 Lakhs	☐ Rs.9.5 Lakhs	☐ Rs.10 Lakhs

Coverage required from am/pm of DD/MM/YYYY to midnight of DD/MM/YYYY

5. ADD-ON COVERS (on payment of additional premium) - (please tick the option selected)

Covers	☐ **Flexi Op Care-Add-on Cover** UIN: CHOHLIA23045V012223	☐ **Home Care Treatment, Add-On-Cover** UIN: CHOHLIA23045V012223	
Plan options	☐ Flexi OP Care 1 ☐ Flexi OP Care 2 ☐ Flexi OP Care 3 ☐ Flexi OP Care 4	Daily Limit opted – Rs. _____ /-	No. of days per annum – ☐5 ☐7 ☐10 ☐15 ☐20 ☐25 ☐30 ☐45 ☐60
Premium (Excl. GST)			
Discount:			
GST:			
Premium (incl. GST)			

On opting for the Add on cover by paying applicable premium, the same will be applicable for all the Insured members as defined under the add on cover individually, irrespective of Base Individual / Family Floater policy.

6. MEDICAL INFORMATION

Do any of the persons proposed for insurance have any physical or mental illness / deformities / impairments / undergone any surgeries?		☐ Yes ☐ No
Have any of the persons who are proposed for insurance ever suffered from / are suffering from any of the following: Please tick wherever applicable and provide details in the table below	Yes / No	Insured
Diabetes, sugar, albumin / blood in urine	Y N	1 2 3 4 5 6
High blood pressure, chest pain, heart murmur, shortness of breath, angina or other heart / circulatory disorder	Y N	1 2 3 4 5 6
Stroke, epilepsy, fainting, dizziness, headaches, disorder of the brain / nervous system	Y N	1 2 3 4 5 6
Tuberculosis, asthma, hay fever, lung respiratory disorder	Y N	1 2 3 4 5 6
Stomach or duodenal ulcer (of any kind),colitis, disorder of gall bladder, liver, stomach or intestines	Y N	1 2 3 4 5 6
Varicose veins, varicose ulcers, phlebitis or hernia of any kind	Y N	1 2 3 4 5 6
Kidney / bladder / prostate disorder or other urinary disorder	Y N	1 2 3 4 5 6
Tumor / disease / dysfunction/ of the breast or reproductive organs /abnormal menstrual period / DUB / Fibroid / Cysts / Prolapsed Uterus	Y N	1 2 3 4 5 6
Arthritis, rheumatism or any pain / disorder of the joints / muscle / back / bones	Y N	1 2 3 4 5 6

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Cancer / tumour / ulcer of any kind, growth or cyst of any kind	Y N	1 2 3 4 5 6
Disorder of eyes / ears / nose / throat	Y N	1 2 3 4 5 6
Nervous / mental / sleep disorder / Psychiatric disorders	Y N	1 2 3 4 5 6
Disease of immune system such as AIDS / ARC	Y N	1 2 3 4 5 6
Disease of blood forming organs as anemia and leukemia	Y N	1 2 3 4 5 6
Thyroiditis / Goitre	Y N	1 2 3 4 5 6
Prolapse or Fibroid in reproductive organs	Y N	1 2 3 4 5 6
*Alcoholism ,drug habit	Y N	1 2 3 4 5 6
*If yes, please state the consumption quantity		
*Tobacco (Cigarettes, cigar, pipe, chewing tabacco or bidis)	Y N	1 2 3 4 5 6
*If yes, please state the consumption quantity		

*Mandatory fields

If you answered 'Yes' to any of the above questions, give the details in the table below

Name of the persons to be Insured	Illness	Date of last consultation	Treatment undergone	Name of the Doctor	Hospital Name & Ph. No.	Present Status

7. ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

I want Policy related information in Physical Format – □ Yes / □ No
e-Format (electronic) as & when applicable – □ Yes / □ No

Choose your Insurance Repository (For those selecting e-Format)
□ NSDL Data Management Ltd □ Karvy Insurance Repository Ltd
□ CAMS Repository Services Ltd □ CDSL Insurance Repository Ltd

I have e Insurance Account & the No. is ----------

My CKYC No. (Central Know Your Customer registry number) is (If available) ----------

8. DETAILS OF OTHER EXISTING HEALTH INSURANCE

Name of the Insured	Insurance Company	Policy No.	Policy Period		Sum Insured	Type of Cover (Individual/ Family Floater)	Type of policy (Indemnity/ Benefit)	Claims lodged	Claim free Bonus (if applicable) From To in Rs.
			From	To					

9. PREMIUM PAYMENT DETAILS (* Cheque / Draft to be drawn in favour of "Cholamandalam MS General Insurance Company Limited")

PREMIUM PAYMENT MODE (please tick the mode selected)

☐ Single Premium Payment Mode ☐ Annual Mode ☐ Half Yearly Mode ☐ Quarterly Mode ☐ Monthly Mode

Premium to be paid is as below with the filled in Proposal form:

- Yearly Mode – Premium applicable for the policy including GST
- Half-Yearly Mode – Premium applicable for the first Half of the policy year including GST
- Quarterly Mode – Premium applicable for the first Quarter including GST

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- Monthly Mode – Premium applicable for first 3 Months including GST

I confirm to Cholamandalam MS General Insurance Company Limited to utilize the Debit Mandate form signed and submitted by me for the purpose of debiting the applicable modal premium and renewal premium ☐ Yes ☐No

Signature / Thumb Impression of Proposer	Date: DD/MM/YYYY	Place

(For Office Use Only)

Single Premium Payment Mode	Other than Single Premium Payment Mode
Premium Payable for the policy tenure(excluding GST) Rs.	Premium Payable for the policy tenure(excluding GST) Rs.
GST: Rs.	Modal Premium Payable: Rs. GST: Rs.
Premium (including GST): Rs.	Modal Premium (including GST): Rs.
Total Premium payable including Add-on covers & GST: Rs.	
☐ Cheque */ ☐ Draft */☐ PO* Number :	Date: **DD/MM/YYYY**
Transaction Reference No. for Online Transfer:	Transaction Date:
Amount (Rs.)	Amount (in words):
Bank Name:	Bank Branch:

For direct payment of claims / refunds in the account, please fill the following (Please enclose a cancelled cheque leaf)

Name of the Bank:	Branch
MICR Code:	IFSC Code:
Account No.:	

10.DECLARATION

- 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.
- 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.
- I further declare that I will notify in writing any change occurring in the occupation or general health of life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- I declare that I consent to the company seeking medical information from any doctor or from a hospital who/which at anytime 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.
- 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 Governmental and/or Regulatory Authority.

ABHA Declaration: I/We hereby authorize and give my/our consent to Company to collect my/our personal and medical information/data available in my/ our Ayushman Bharat Health Account (ABHA). Further I/we hereby authorise Company to use/share the information/data, pertaining to my proposal and/or collected from my/our ABHA, with reinsurer, Service Provider and or with any Governmental and/or Regulatory authority, for the sole purpose of proposal underwriting and/or claims settlement and or to comply with applicable laws/regulations

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DPDP Act 2023, Declaration: I/We confirm that I/We have provided personal data for the purpose of securing insurance policy/policies of the Insurer and I /We hereby provide express consent under Sec 6 of DPDP act, 2023 for the use and processing of such personal data by the Insurer for the purpose of the insurance		
AML Guidelines: I/We here by confirm that all premium have been / will be paid from bonafide sources and no premium have been / will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002. I/We understand that the Company has the right to call for documents to establish source of funds. The insurance Company has the right to cancel the insurance contract in case I am / have been found guilty by any competent court of law under any statues, directly or indirectly governing the prevention of money laundering in India.		
Signature / Thumb Impression of Proposer	Date: DD/MM/YYYY	Place:
The Insurance Agent/Intermediary has explained Product Features and Suitability clearly and in the language understandable to me. Yes ☐ No☐		
Signature / Thumb Impression of Proposer	Date: DD/MM/YYYY	Place:

Note:

- Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the Insured will nullify the cover under the policy.
- Please get your queries clarified before signing the proposal form

STATUTORY WARNING

Section 41 of Insurance Act, 1938 – Prohibition of Rebates: (1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take 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.

For office use only (Documents submitted with this proposal-Please tick)			
Premium Cheque : ☐ Yes ☐ No	ECS Form : ☐ Yes ☐ No	Receipt No.	

Insurance is the subject matter of the Solicitation