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

REACH US THROUGH WHATSAPP 7305234433

PROPOSAL FORM

CHOLA FLEXI HEALTH SUPREME

Product UIN: CHOHLIP22036V022122 / Proposal URN: Chola-FHS-Ret-116-2021

(For Office Use Only)	Intermediary Name:	Intermediary Code:

POSP Name:		POSP PAN:	

1. INFORMATION ABOUT THE PROPOSER

Personal Details

Name			
Date of Birth: DD/MM/YYYY	Gender: ☐ Male ☐ Female ☐ Others	Marital Status: ☐ Single ☐ Married ☐ Others	
Occupation: ☐ Salaried ☐ Self-Employed ☐ Others			
☐ PAN* ☐ Passport ☐ DL No._____			
Nationality ☐ Resident Indian ☐ Non Resident Indian (NRI) ☐ Person of Indian Origin (PIO) ☐ Foreign Nationals			
Mobile No: +91		Tel (O) +91	Extn: Tel (R) +91
GSTIN		*Email ID:	

Address

Door / Flat No:	Building No / Name:		
Street Name:		Landmark:	
Sub Area / Village:		Area / Tehsil:	
City:	District:	PIN:	State:

*Mandatory fields

Existing CHOLA MS Customer: ☐ Yes ☐ No	If Yes, Provide Policy Number:

The below details are necessary for payment of any claim, refund or cancellation of Policy (Please attach one cancelled cheque leaf)

Name of the Bank & Branch_____

A/c. No._____ IFSC Code _____ MICR Code _____

2. INFORMATION OF THE PERSONS TO BE INSURED

Sl. No.	Name of the Persons to be Insured	Gender (M/F/ Others)	Relationship with the Proposer	Date of Birth	Sum Insured	*Height in Cms	*Weight in Kgs	Marital Status	*Occupation	ABHA Number (14 digits)#
				DD/MM/YYYY						
				DD/MM/YYYY						
				DD/MM/YYYY						
				DD/MM/YYYY						
				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
- *Mandatory fields
- #Ayushman Bharat Health Account

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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:	
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. DETAILS OF COVERAGE

Policy Type: ☐ Individual ☐ Family Floater	Policy Tenure: ☐ 1 Year ☐ 2 Years ☐ 3 Years	
Plan	Plus	Premiere
Sum Insured (in ₹)	☐ 5 Lakhs ☐ 7.5 Lakhs ☐ 10 Lakhs ☐ 15 Lakhs ☐ 20 Lakhs ☐ 25 Lakhs	☐ 30 Lakhs ☐ 40 Lakhs ☐ 50 Lakhs ☐ 75 Lakhs ☐ 1 Crore ☐ 2 Cores ☐ 2.5 Crores ☐ 3 Cores ☐ 5 Crores
Coverage required from am / pm of DD/MM/YYYY		to midnight of DD/MM/YYYY
Medical Second Opinion-Add-on Cover UIN:CHOHLIA19048V011920 (on payment of additional premium)		☐ Yes ☐ No
On opting for the Medical Second Opinion cover by paying applicable premium, the same will be applicable for all the Individual Insured members under the base Individual or Family Floater policy. The proposer will not have an option to exclude the insured members from this cover.		
Premium (Excl. GST)	Discount:	
GST:	Premium (incl. GST)	

Flexi Op Care- Add on Cover- CHOHLIA23045V012223 (on payment of additonal premium)	
☐ Flexi OP Care 1 ☐ Flexi OP Care 2 ☐ Flexi OP Care 3 ☐ Flexi OP Care 4	
On opting for the Add on cover by paying applicable premium, the same will be applicable for all the Insured members (barring siblings) as defined under the add on cover individually, irrespective of Base Individual / Family Floater policy.	
Premium (Excl. GST)	Discount:
GST:	Premium (incl. GST)

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5. MEDICAL AND OTHER DETAILS OF THE PERSONS TO BE INSURED

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
Any glandular disorders e.g. diabetes, thyroid, goiter hormonal problems etc	☐ Yes ☐ No	1 2 3 4 5 6
Any circulatory disorders e.g. varicose veins, high cholesterol, deep vein thrombosis, high blood pressure, venous ulcers, any heart related problem or symptoms like chest pain, shortness of breath, dyspnea on exertion etc.	☐ Yes ☐ No	1 2 3 4 5 6
Any brain or nervous system disorders e.g. migraines, headaches, multiples sclerosis, stroke, epilepsy, nerve pain, fits etc	☐ Yes ☐ No	1 2 3 4 5 6
Any breathing or respiratory disorders e.g. Tuberculosis, COPD, asthma, bronchitis, chest infections, lung disease etc	☐ Yes ☐ No	1 2 3 4 5 6
Any digestive system problem e.g. ulcer, colitis, indigestion, irritable bowel, hepatitis, piles, hernia etc.	☐ Yes ☐ No	1 2 3 4 5 6
Any urinary system problems e.g. stones, bladder or prostate problems, urinary infections, incontinence, cystitis, phimosis, paraphimosis, stricture etc	☐ Yes ☐ No	1 2 3 4 5 6
Any Tumor / disease / dysfunction of the breast or any male/ female reproductive organs , abnormal menstrual period , DUB , Fibroid , Cysts , endometriosis, Prolapsed Uterus, infertility etc	☐ Yes ☐ No	1 2 3 4 5 6
Any muscle or skeletal problems e.g. arthritis, cartilage and ligament problems, back and neck problems, sprains, gout, sciatica etc	☐ Yes ☐ No	1 2 3 4 5 6
Cancer / tumour / ulcer of any kind, growth or cyst of any kind	☐ Yes ☐ No	1 2 3 4 5 6
Any ear, nose, throat or eye problems e.g. hay fever, tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections, ear drum perforation etc	☐ Yes ☐ No	1 2 3 4 5 6
Nervous / mental / sleep disorder / Psychiatric disorders	☐ Yes ☐ No	1 2 3 4 5 6
Disease of immune system such as AIDS / ARC	☐ Yes ☐ No	1 2 3 4 5 6
Any blood disorders e.g. anaemia, leukaemia , Thalassemia, abnormal blood tests etc	☐ Yes ☐ No	1 2 3 4 5 6
Any skin problems e.g. eczema rashes, psoriasis, allergy, acne etc	☐ Yes ☐ No	1 2 3 4 5 6
Any infectious disease e.g. COVID19, fungal infection, filariasis, infective encephalitis, leptospirosis etc	☐ Yes ☐ No	1 2 3 4 5 6

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any dental problems e.g. wisdom teeth problems, abscesses or gingivitis etc	☐ Yes ☐ No	1 2 3 4 5 6
Any other illness, deformities / impairments / surgeries etc which is not covered under above questions.	☐ Yes ☐ No	1 2 3 4 5 6
*Alcoholism	☐ Yes ☐ No	1 2 3 4 5 6
*Drug addiction or Narcotics consumption	☐ Yes ☐ No	1 2 3 4 5 6
*If yes, please state the consumption quantity as ml/day or / week or /month		
*Tobacco (Cigarettes, cigar, pipe, chewing tabacco or bidis)	☐ Yes ☐ No	1 2 3 4 5 6
*If yes, please state the consumption quantity as sticks/day or pouch/day		
*Mandatory fields		

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

S. No.	Name of the Persons to be Insured	Illness	Date of last consultation	Name/ Address of Doctor	Treatment	Period of treatment	Name/ Address of Hospital	Present Status

6. ELECTRONIC INSURANCE ACCOUNT DETAILS

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)

☐ (a) NSDL Data Management Ltd

☐ (b) CDSL Insurance Repository Ltd

☐ (c) Karvy Insurance Repository Ltd

☐ (d) CAMS Repository Services Ltd

I have e Insurance Account & the No. is _____

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

7. DETAILS OF PREVIOUS / EXISTING HEALTH INSURANCE POLICY

Do any of the proposed members have any existing Health Insurance Cover? If Yes, provide following details

Name of the Persons to be Insured	Insurance Company	Details of Coverage Source	Expiring Policy No.	Date of Commencement of Cover*	Policy Expiry Date*	Sum Insured ₹	Claim Details	Claim free Bonus (if applicable)* in ₹
				DD/MM/YYYY	DD/MM/YYYY			

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				DD/MM/YYYY	DD/MM/YYYY			
				DD/MM/YYYY	DD/MM/YYYY			

Details of coverage source: IH – Individual Health; FH – Family Floater Health; OH – Other Health Policy
Date of commencement of cover for first time, please enter start date of your existing / previous health Insurance Policy
* Please attach previous policy copies and renewal notices as proof for the initial commencement date

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

PREMIUM PAYMENT MODE (please tick the mode selected)

☐ Single payment Mode ☐ Annual Mode ☐ Half Yearly Mode ☐ Quarterly Mode ☐ Monthly Mode

In the event of opting for other than single payment mode, Premium to be paid is as below with the filled in proposal form:
• Monthly Mode – Premium applicable for first 3 Months including GST

• Quarterly Mode – Premium applicable for the first Quarter including GST
• Half-Yearly Mode – Premium applicable for the first Half of the policy year including GST
• Annual Mode – Premium applicable for the first policy year of the policy period 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 Auto renewal of the policy. ☐ 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) ₹	Premium Payable for the policy tenure (excluding GST) ₹
GST ₹	Modal Premium Payable: ₹ GST: ₹
Premium (including of GST) ₹	Modal Premium (including of GST) ₹
☐ Include Add-on cover premium, if opted	

Cheque */ Draft */ PO* Number:	Date: DD/MM/YYYY
Transaction Reference No. for Online Transfer:	Transaction Date:
Amount ₹	Amount (in words):
Bank Name:	Bank Branch:

9. 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 as per the premium payment mode opted.

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 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.

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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.

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	Signature of the Insurance Agent/Intermediary Date: DD/MM/YYYY

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.

For office use only (Documents submitted with this Proposal (Pl. √)

Expiring policy with schedule	☐ Yes	☐ No	Premium Cheque:	Receipt Date: DD/MM/YYYY
Original renewal notice	☐ Yes	☐ No		

In case you need any further details regarding the policy, you may contact our Tollfree No:1800 208 9100.
Please get your queries clarified before signing the proposal form.

UMRN: For office use only **Date:** DD MM YYYY

Sponsor Bank Code: CITI000PIGW

Utility Code: CITI00002000000037

Tick (✓)	
Create	✓
Modify	
Cancel	

I/We hereby authorise: Cholamandalam MS General Insurance Company Ltd.

To debit (tick): SB/CA/CC/SBNRE/SB-NRO/Other

Bank a/c number

With bank

IFSC

or MICR

an amount of Rupees: Amount in Words

₹

Frequency ☒ Mthly ☒ Qtly ☒ H-Yrly ☒ Yrly ☑ As & when presented

Debit Type ☒ Fixed Amount ☑ Maximum Amount

Reference 1

Phone No.

Reference 2

Email ID

I agree to the debit of mandate processing charges by the bank whom I am authorising to debit my account as per latest schedule of charges of the bank.

PERIOD

From

To

1. Signature of Primary Account holder
Name as in Bank Records

2. Signature of the Account holder
Name as in Bank Records

3. Signature of the Account holder
Name as in Bank Records

• This is to confirm that the declaration has been carefully read, understood and made by me/us. I am authorising the user entity/corporate to debit my account • I have understood that I am authorized to cancel/amend this mandate by appropriately communicating the cancellation/amendment request to the user entity/corporate or the bank where I have authorised the debit.