Chola MS
GENERAL INSURANCE

Proposal No.
HL

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

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(For Office Use Only)	Intermediary Code :	Intermediary Name :	Intermediary Signature :
Office	Employee Name:		Customer ID

PROPOSAL FORM

Proposal form URN: Chola MS-Health-003-2016

CHOLA HEALTHLINE

UIN: CHOHLIP24153V052425

This proposal form needs to be filled for a new policy and renewal from other Chola MS Health policies. Write in CAPITAL LETTERS using a black pen only. Photographs are mandatory. Please attach additional sheet if required with relevant details and signature of proposer. Cash can be accepted only by office.

POSP Name	POSP PAN

1. INFORMATION ABOUT THE PROPOSER

Personal Details	Name			
	Date of Birth: DD/MM/YYYY	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Others	
	Occupation	☐ Salaried ☐ Self-Employed ☐ Others	☐ Passport ☐ DL No	
	Mobile No: +91		Tel (O) +91 Extn:	Tel (R) +91
	PAN Card No.		GSTIN:	
	ISD (Input Service Distriburtion No.):		Email ID:	
Correspondence Address	Door / Flat No:	Building No / Name:		
	Street Name:		Landmark:	
	Sub Area / Village:		Area / Tehsil:	
	City:	District:	State:	Pincode:
Permanent Address	Door / Flat No:	Building No / Name:		
	Street Name:		Landmark	
	Sub Area / Village:		Area / Tehsil:	
	City:	District:	State:	Pincode:

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)
Name of the Bank & Branch_____

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

2. INFORMATION OF THE PERSONS TO BE COVERED

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

3. DETAILS OF NOMINEE FOR PROPOSER (for other members, proposer will be the Nominee)

Name		Male	Female	Relationship with Proposer		Age (in years)
Address:						

In case you are opting for a floater policy, please mention the floater Sum Insured against the Proposer's name
Nominee details are mandatory. We do not get any separate nomination form signed. In case the nominee is a minor, the guardian details will have to be provided.

*Pre policy health checkup is required for age above 45 years. Please contact our nearest branch.

4. DETAILS OF PREMIUM AND COVERAGE

Policy Type:	☐ Individual ☐ Family Floater	Location:	☐ Tier 1: Mumbai, Chennai, Bengaluru, Kolkatta, New Delhi, Gurgaon, Hyderabad, Ahmedabad
Policy Duration:	☐ 1 Year ☐ 2 Year ☐ 3 Year		☐ Tier 2: Rest of India excluding Tier 1 Locations

Plan and Sum Insured Options	☐ Value Healthline	☐ ₹100000 ☐ ₹200000 ☐ ₹300000 ☐ ₹500000 ☐ ₹750000 ☐ ₹1000000
	☐ Freedom Healthline	☐ ₹200000 ☐ ₹300000 ☐ ₹500000 ☐ ₹750000 ☐ ₹1000000 ☐ ₹1500000
	☐ Enrich Healthline	☐ ₹300000 ☐ ₹500000 ☐ ₹750000 ☐ ₹1000000 ☐ ₹1500000 ☐ ₹2000000 ☐ ₹2500000
	☐ Previlege Healthline	☐ ₹500000 ☐ ₹750000 ☐ ₹1000000 ☐ ₹1500000 ☐ ₹2000000 ☐ ₹2500000

Premium (inclusive of GST tax) ₹

Coverage required from am / pm of to Midnight of

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

Do you or any of the persons proposed for insurance have any physical or mental illness/ deformities/ impairments/ undergone any surgeries?	Yes ☐ No ☐

If, yes and if you or any of the persons proposed for insurance suffered from any of the following ailments/ diseases, please give the details in the table.
List of diseases: High blood pressure, Chest pain or any other heart disease, Diabetes/ High Blood Sugar, disorder of the brain/ nervous system, Tuberculosis, Asthma, Stomach or duodenal ulcer of any kind, stroke, epilepsy, disorder of gall bladder, liver, stomach or intestines, Varicose veins, varicose ulcers, hernia of any kind, kidney/ bladder/ prostrate disorder, abnormal menstrual period/ DUB (Dysfunctional Uterine Bleeding/ Fibroid Uterus/ Cysts, Arthritis Rheumatism or any pain/ disorder of bone & joints, Cancer/ tumour/ ulcer of any kind/ extra growth or cyst of any kind. Any other illness or disease.

Sl. No.	Name of the persons to be Insured	Illness	Date of treatment	Name/ Address of Doctor	Period of treatment	Name / Address of Hospital	Present status
1							
2							
3							
4							
5							

6. ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

I want policy related information in Physical Format ☐ Yes / ☐ No

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E-Format (electronic) as & when applicable ☐ Yes / ☐ No	
Choose your Insurance Repository (For those selecting e-format)	
☐ NSDL Data Management Ltd.	☐ Karvy Insurance Repository Limited
☐ CDSL Insurance Repository Limited	☐ CAMS Insurance Repository Services Limited
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 ₹

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")

Amount ₹	Amount (in words)
*Cheque / Draft / PO Number	Date DD/MM/YYYY
☐ Self Cheque ☐ Third Party (TP) Cheque - If TP cheque please indicate the nature of relationship with the insured.	
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 or 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 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.
- 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.

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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:
Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub- section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.
(2) Any person making default in complying with the provisions of this section shall be liable fora penalty which may extend to ten lakh rupees.

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 Toll free No: 1800 208 9100.

Please get your queries clarified before signing the proposal from.

Please visit our website for details about the product and policy wordings.

Receipt of proposal form shall not be construed as acceptance of proposal.

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ACKNOWLEDGEMENT SLIP

PROPOSAL NO: HL_____

We hereby acknowledge with thanks from Mr. / Mrs. / Ms .... receipt of sum of Rs.....

(Rs. in words ..... by means of cash/ cheque*/ DD Number ..... dated

...../ ...../ .....drawn on ..... (bank Branch) in our favour along with the proposal for Health

insurance for the period from ..... to .....

Kindly note that, the liability of Cholamandalam MS General Insurance Company Limited. commences only upon acceptance of risk and issuance of policy.
*Subject to realisation.

Name of the Intermediary .....

Intermediary Code ..... Date: .....

Authorized Signatory
For Cholamandalam MS General Insurance Company Limited