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 SURROGATE AND OOCYTE DONOR PROTECTOR

UIN: CHOHLIP24093V012324 / Proposal URN: Chola-SODP-181-2023

(For Office Use Only)		Sl No	
Intermediary Name		Intermediary Code	

1. INFORMATION ABOUT THE PROPOSER

Proposer Type	☐ Intending Couple		☐ Intending Woman
Name	Male:	Female:	
Please mention the name of the Proposer			Intending women will be considered as proposer by default
Date of Birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Age			
Occupation	☐ Salaried ☐ Self-Employed ☐ Others, Pls specify _____	☐ Salaried ☐ Self-Employed ☐ Others, Pls specify _____	☐ Salaried ☐ Self-Employed ☐ Others, Pls specify _____
*ID Proof	☐ PAN _____ ☐ Passport_____ ☐ DL No._____ Any Other ID with No. _____	☐ PAN ☐ Passport ☐ DL No. Any Other ID with No. _____	☐ PAN _____ ☐ Passport_____ ☐ DL No._____ Any Other ID with No. _____
Nationality#	☑ Resident Indian	☑ Resident Indian	☑ Resident Indian
Marital Status			☐ Widow ☐ Divorcee
*Mobile No.	+91	+91	+91
Tel (R)			

#Policy can be proposed and purchased by Indian Nationals only

2. OTHER DETAILS OF THE PROPOSER

GSTIN		*Email ID	
Door / Flat No		Building No / Name	
Street Name		Landmark	
Sub Area / Village		Area / Tehsil	

City District PIN State

*Mandatory fields

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 _____

Details of the Clinics / Hospitals

Name of the Clinic/Hospital

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Registration No. of Clinic /Hospital	Validity Period: From DD/MM/YYYY To DD/MM/YYYY

3. INFORMATION OF THE PERSONS TO BE INSURED

Type of Insured person (pls tick as applicable)			☐ **Surrogate Mother**			☐ **Oocyte Donor**		
Name of the Persons to be Insured	Date of Birth	Height in Cms	Weight in Kgs	Marital Status	Occupation	No of live children (in case of surrogate mother)	Nationality	ABHA Number (14 digits)#
	DD/MM/YYYY							
	DD/MM/YYYY							

#Ayushman Bharat Health Account

4. DETAILS OF COVERAGE

Policy Type: ☐ Individual	Policy Tenure (please tick): ☐ 3 years for Surrogate Mother ☐ 1 year for Oocyte Donor		
Sum Insured (in Rs.) (Please Tick)	☐ 3 lakhs	☐ 5 lakhs	☐ 7.5 lakhs ☐ 10 lakhs
Coverage required from am/pm of	DD/MM/YYYY	to midnight of	DD/MM/YYYY
Premium (Excl. GST)		GST	
Premium (incl. GST)			

5. NOMINATION [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]

Nominee Name	Nominee Relationship with the Insured
Nominee Contact Details	
Nominee mentioned above is for the proposer. For other members covered under the policy, proposer is deemed to be the nominee.	

6. SUPPORTING MANDATORY DOCUMENTS TO BE SUBMITTED WITH THE PROPOSAL FORM BY THE PROPOSER & INSURED

INTENDING COUPLE / WOMAN	☐ 1. Certificate of recommendation from the National Assisted Reproductive Technology and Surrogacy Board
	☐ 2. Certificate of essentiality issued by the appropriate authority constituted as per section 35 of The Surrogacy (Regulation) Act, 2021
	☐ 3. Certificate of a medical indication in favour of either or both members of the intending couple or indenting woman necessitating gestational surrogacy from a District Medical Board
	☐ 4. Eligibility certificate issued in favour of the Intending couple or woman by the appropriate authority, constituted as per section 35 of The Surrogacy (Regulation) Act, 2021
SURROGATE MOTHER	☐ 1. Eligibility certificate issued in favour of the Surrogate Mother by the appropriate authority, constituted as per section 35 of The Surrogacy (Regulation) Act, 2021
	☐ 2. Certificate of medical and psychological fitness of the Surrogate Mother for surrogacy and surrogacy procedures from a registered medical practitioner
OOCYTE DONOR	☐ 1. Form 13 – Consent form for the Donor of Oocytes as prescribed in The Assisted Reproductive Technology (Regulation) Rules, 2022

Disclaimer: The Company may contact you for matters related to your policy or to provide details of products & services offered. To opt out from the facility, please register under Do Not Call section on our website.

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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 Rs.	Claim details	Claim free Bonus (if applicable)* in Rs

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. 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 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)

9. PREMIUM PAYMENT INFORMATION [* Cheque / Draft to be drawn in favour of "Cholamandalam MS General Insurance Company Limited"]

PREMIUM PAYMENT MODE : Single payment Mode

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)

Premium Payable for the policy tenure (excluding GST) Rs.	
GST Rs.	
Premium (including of 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

10. DECLARATION OF THE SURROGATE MOTHER

i. I certify that I have not born any child through Surrogacy before the commencement of this policy
ii. I have been tested for HIV, Hepatitis B, and Hepatitis C and shown to be seronegative for these viruses before embryo transfer.
iii. I have not provided my own gametes for the purpose of surrogacy
iv. I have not act as a surrogate mother more than once in lifetime

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

11. DECLARATION OF THE OOCYTE DONOR

i. I have donated oocytes only once in lifetime
ii. I am free from any of infectious disease or genetic disorder

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

12. DECLARATION OF THE INTENDING COUPLE / WOMAN

i. I/We certify that the Surrogacy procedure / Oocyte Retrieval procedure will be carried out in Registered Surrogacy Clinic / Assisted Reproductive Technology Bank/Clinic in compliance with THE SURROGACY (REGULATION) ACT, 2021 and THE ASSISTED REPRODUCTIVE TECHNOLOGY (REGULATION) ACT, 2021 respectively.
ii. I/We shall not have the service of more than one surrogate at any given time
iii. I/We shall not have simultaneous transfer of embryos in the woman and in a surrogate.

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

13. DECLARATION BY THE PROPOSER

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.

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.

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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 Toll free No: 1800 208 9100.
Please get your queries clarified before signing the proposal from