

CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED

Registered Office: 2nd Floor "DARE House", 2, N.S.C. Bose Road, Chennai - 600 001

T: +91 (0) 44 4044 5400, F: +91 (0) 44 4044 5550

IRDA Regn. No.123 | PAN AABCC6633K | CIN: U66030TN2001PLC047977

REACH US THROUGH WHATSAPP  **7305234433**

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

Proposal form URN: Chola MS-Comp Travel-026-2017

CHOLA COMPREHENSIVE TRAVEL INSURANCE POLICY

UIN: IRDAI/HLT/CHSGI/P-T/V.I/66/2016-17

1. INFORMATION ABOUT THE PROPOSER

Personal Details	Name of the Proposer						
	Date of Birth			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
	Occupation						
	Annual Income of Proposer (in Rs.)			Visa Type <input type="checkbox"/> Non-immigrant <input type="checkbox"/> Immigrant			
	PAN			Aadhar No.			
	GST No.						
Address	Door / Flat No		Building No / Name				
	Street Name			Landmark			
	Sub Area / Village			Area / Tehsil			
	City		District		State		Pincode
	STD Code		Phone no.		Mobile No.		Fax
Nomination Details	*Name of the Nominee						
	Relationship with the Proposer						
	Contact Address and Phone No. of the Nominee						
*Nominee details are mandatory. We do not get any separate nomination form signed. In case the nominee is a minor, the appointee (guardian) details and signature of appointee is required.							
Existing CHOLA MS Customer <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provide Policy Number with Customer Code							

2. DETAILS OF THE PERSONS TO BE INSURED

Sl. No.	Name of the persons to be insured	Gender (M/F)	Date of Birth	Relationship with the proposer	Passport No.	Plan	Sum Insured	*Risk Type N/R1/R2
1			DD/MM/YYYY					
2			DD/MM/YYYY					
3			DD/MM/YYYY					
4			DD/MM/YYYY					
Sl. No.	Name of the persons to be insured	Optional Covers on payment of Additional Premium (Please tick the cover opted)						
		Hospital Daily Cash	Hijack Relief	Pre existing illness Extension	Ambulatory Care Services	Bounced booking of Hotel	Domestic Covers	
1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Normal: All other persons/ occupation other than those described below Risk 1: Professional and semi-professional sportsmen Risk 2: Participation in dangerous sports of any kinds whether for leisure or otherwise, during the overseas travel.					
Have any of the persons proposed for insurance been admitted to any hospital / nursing home, clinic for treatment or observation, If so please give details.					
Have any of the persons proposed for insurance ever suffered from any illness/disease or deformity or physical defect upto date of this proposal. If so, please give details.					
Risk Start Date		Risk End Date			
Policy Type	<input type="checkbox"/> Single Trip	<input type="checkbox"/> Annual Multi-Trip	Maximum Trip, duration for Annual Multi-Trip	<input type="checkbox"/> 30 days <input type="checkbox"/> 45 days <input type="checkbox"/> 60 days	
Geographical Scope		<input type="checkbox"/> Worldwide <input type="checkbox"/> World Excluding USA & Canada <input type="checkbox"/> Asia <input type="checkbox"/> Asia Excluding Japan			
Plan and Sum Insured Options			Travel Plus	Travel Pleasure	Travel Delight
			\$ 50,000	\$ 50,000	\$ 50,000
			\$1,00,000	\$1,00,000	\$1,00,000
			\$ 2,50,000	\$ 2,50,000	\$ 2,50,000
			\$ 3,50,000	\$ 3,50,000	\$ 3,50,000
			\$ 5,00,000	\$ 5,00,000	\$ 5,00,000
Optional Covers (on payment of additional premium) Sum Insured in USD except where specifically mentioned	Hospital Daily Cash		150 (15/day max 10 days)	250 (25/day max 10 days)	400 (40/day max 10 days)
	Hijack Relief		350 (50/day max 7 days)	350 (50/ day max 7 days)	700 (70/day max 10 days)
	Pre-existing Illness extension		upto 5% of the Sum Insured Applicable for Overseas Medical Expenses		
	Ambulatory Care Service				
	Bounced Booking of Hotel		1500		
Optional Domestic covers (on payment of additional premium)Sum Insured in INR	Domestic Covers	a. Personal Accident	Rs.10,00,000	Rs.15,00,000	Rs.25,00,000
		b. Accidental Medical Expenses	Rs.1,00,000	Rs.1,50,000	Rs. 2,50,000
		c. Repatriation of Mortal remains	Rs.10,000	Rs.10,000	Rs.10,000

3. 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 below.

List of diseases: High blood pressure, Chest pain or any other Heart disease, Diabetes / 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 / Fibroid / Cysts, Arthritis rheumatism or any pain / Disorder of the Joints, Cancer / Tumour / Ulcer of any kind, growth of 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
1						
2						
3						

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4					
5					

4. 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)

<input type="checkbox"/> NSDL Data Management Ltd.	<input type="checkbox"/> Karvy Insurance Repository Limited
<input type="checkbox"/> CDSL Insurance Repository Limited	<input type="checkbox"/> 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)

5. PREMIUM PAYMENT INFORMATION [*CHEQUE / DRAFT TO BE DRAWN IN FAVOUR OF "CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED"]

Cheque */ Draft */PO Number :	Date	
Amount (Rs.)	Amount (in words)	
Bank Name	Bank Branch	
(The below details are necessary for payment of any claim, refund or cancellation of Policy)		
Name of the Bank and Branch:		
A/c No.	IFSC Code No.	MICR Code

6. ADDITIONAL INFORMATION

7. 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 the 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 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.

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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:
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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
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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 prospectus 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 (Pl. '✓')			
Expiring policy with schedule	<input type="checkbox"/> Yes <input type="checkbox"/> No	Premium Cheque:	Receipt Date: DD/MM/YYYY
Original renewal notice	<input type="checkbox"/> Yes <input type="checkbox"/> 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 form.