Chola MS
GENERAL INSURANCE

Sl No.

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 Name :			
	Intermediary Code:		Customer ID:	

PROPOSAL FORM

Proposal URN: Chola-Flexisupertop-099-2020

CHOLA FLEXI SUPER TOPUP INSURANCE

UIN: CHOHLIP23049V022223

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, Pls Specify				
	☐ PAN* ☐ Passport ☐ DL No *Copy of PAN card is mandatory if the premium is Rs1 Lakh or more					
	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:	State:		Pincode:	

Existing CHOLA MS Customer ☐ Yes ☐ No	If Yes, Provide Policy Number
Portability ☐ Yes ☐ No	If Yes, Portability form to be completed and attached

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 COVERED

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

3. NOMINATION

Nominee Name:	Nominee Relationship with the Insured
Nominee Contact Details	

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

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

4. DETAILS OF PREMIUM AND COVERAGE

Policy Type: ☐ Individual ☐ Family Floater		Term of Coverage: ☐ 1 Year ☐ 2 Years ☐ 3 Years
PLANS	SILVER ☐	GOLD ☐
Sum Insured Options (in lacs) (Please tick the Sum Insured opted)		Deductibles options (in lacs) (Please tick the Deductible opted)
☐ ₹ 5 Lacs		☐ 5 ☐ 10
☐ ₹ 7.5 Lacs		☐ 5 ☐ 7.5
☐ ₹ 10 Lacs		☐ 5 ☐ 7.5 ☐ 10
☐ ₹ 15 Lacs		☐ 5 ☐ 10
☐ ₹ 20 Lacs		☐ 5 ☐ 10 ☐ 15
☐ ₹ 25 Lacs ☐ ₹ 30 Lacs ☐ ₹ 35 Lacs ☐ ₹ 40 Lacs ☐ ₹ 45 Lacs		☐ 5 ☐ 10 ☐ 15 ☐ 20
☐ ₹ 50 Lacs		☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25
☐ ₹ 75 Lacs		☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50
☐ ₹ 90 Lacs		☐ 10
☐ ₹ 92.5 Lacs		☐ 7.5
☐ ₹ 95 Lacs		☐ 5
☐ ₹ 1 Crore ☐ ₹ 1.5 Crore ☐ ₹ 2 Crore ☐ ₹ 2.5 Crore ☐ ₹ 3 Crore ☐ ₹ 3.5 Crore ☐ ₹ 4 Crore ☐ ₹ 4.5 Crore ☐ ₹ 5 Crore		☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 1Cr
Coverage required from am / pm of		to Midnight of
(For Office Use Only)		
Add on Cover (on payment of additional premium)– ☐ Medical Second Opinion-Add-on Cover UIN CHOHLIA19048V011920		☐ 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 (excluding of GST) ₹		Discount ₹
GST ₹	Kerala Flood Cess ₹	Premium (including of GST) ₹

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

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

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

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
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
Any other illness or disease	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 Treatment	Name/ Address of Doctor	Period of Treatment	Name/ Address of Hospital	Present Status

6. ELECTRONIC INSURANCE ACCOUNT DETAILS SECTION

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

E-Format (electronic) as & when applicable ☐ Yes / ☐ No

Chola MS
GENERAL INSURANCE

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

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 ₹	Deductible ₹	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)
Cash / *Cheque / *Draft / *PO Number	Date DD/MM/YYYY
☐ Self Cheque	
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.
- 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.

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

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:
(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	☐ 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