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.
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 No. **CH**
Business Segment PL SME COMM
Division : ☐ M&NI ☐ S&D ☐ J&K ☐ MG

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

HEALTH INSURANCE PROPOSAL FORM

Chola MS-Health-009-2016

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 not mandatory. Please attach additional sheet if required with relevant details and signature of proposer.

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	
			Others:	
	Occupation	☐ Salaried ☐ Self-Employed ☐ Others	☐ Passport ☐ DL No	
	Mobile No: +91	Tel (O) +91	Extn:	Tel (R) +91
	PAN Card No.			
	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, please provide the Policy no.

(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.DETAILS OF INSURANCE COVER

☐ **Chola MS Critical Healthline Insurance**	UIN: CHOHLIP21302V022021

(Purchase of policy allowed upto 65 yrs of age for any member. You can renew your policy every year upto your lifetime. Proposal for members above 55 years of age will be accepted only with a medical check-up. You can cover yourself, your spouse, children under the policy)

Please '✓' against Plan required	☐ Standard Plan	☐ Advanced Plan
Please enter Sum insured required for each person in Section 3	₹.3 Lakhs ₹.5 Lakhs ₹.10 Lakhs	

☐ **Chola Hospital Cash Healthline (Revision)**	UIN: CHOHLIP21301V022021

(Purchase of policy allowed upto 65 yrs of age for any member. You can renew your policy every year upto your lifetime. Proposal for members above 55 years of age will be accepted only with a medical check-up. You can cover yourself, your spouse, children, parents under the policy)

Please enter Daily benefit amount required for each person in Section 3	Plan A Maximum upto 20 days ₹. 1000 per day	Plan B Maximum upto 20 days ₹. 2000 per day	Plan C Maximum upto 20 days ₹. 3000 per day	Plan D Maximum upto 25 days ₹. 1000 per day	Plan E Maximum upto 25 days ₹. 2000 per day	Plan F Maximum upto 25 days ₹. 3000 per day

Coverage required from_____AM/PM of DD/MM/YYYY to Midnight of DD/MM/YYYY

Products approved for sale through POSP: 1. Chola MS Critical Healthline Insurance 2. Chola Hospital Cash Healthline (Revision)

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3. INFORMATION ABOUT PROPOSED PERSONS

		1	2	3	4	5	6	7
Name of Proposed Person with initials as required on the Health Card.								
Gender (M/F)								
Relationship								
Marital status Single / Married								
Date of Birth DD/MM/YYYY		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
*Occupation Type								
Weight. in Kgs.								
Height in Cms								
SUM INSURED in Rs.	Chola Hospital Cash Healthline (Revision)							
	Chola MS Critical Healthline Insurance							
ABHA Number (14 Digits)#								
Mobile Number (10 digits only)								
Receipt Amount for Pre-Proposal Health Check-up in Rs. (If applicable)								

*Occupation Type: S -Service, F - Self Employed, B - Business, T - Student, H-Housewife, E- Engaged in Heavy manual work involving the use of heavy tools and machinery (Eg. Construction worker, Welder, Truck Driver and Machinist), 0 - Any other.
#Ayushman Bharat Health Account

4. MEDICAL AND OTHER DETAILS OF PROPOSED PERSONS

(If any of the Questions under section 4 (2 to 8) below have been answered as YES, proposal will not be accepted without a pre-proposal medical Check – up. For details of medical reports required, please check page 5 of this proposal form.)

Please answer all questions by checking either YES or NO box and providing relevant details where applicable

1.	Are all the insured persons now in good health and entirely free from any mental or physical impairments or deformities?	☐ Yes ☐ No
2.	Has any of the insured persons lost or gained over 5 Kgs over the last 12 months?	☐ Yes ☐ No
	If Yes Please give details Name_____ Weight change in Kgs_____ Reason for weight Change: _____	
3.	Is any of the insured persons suffering / suffered from high / low Blood pressure ?	☐ Yes ☐ No
	If Yes give details of BP readings _____	
4.	Have any of the insured persons ever suffered or now suffer from:	
	a) Diseases of the circulatory system (e.g. Heart trouble, Chest Pain, Rheumatic fever, diseases of the arteries and veins)?	☐ Yes ☐ No

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	b) Diseases of the respiratory system (e.g. Tuberculosis, Asthma, Persistent cough, Pneumonia or emphysema)?	☐ Yes ☐ No
	c) Diseases of the genito-urinary system (e.g. Infections of the Kidneys, Urinary or Genital organs, Renal stones, Venereal disease)?	☐ Yes ☐ No
	d) Diseases of the gastrointestinal system (e.g. Digestive disorders, Gastric or Duodenal ulcer, Hepatitis B, Hepatitis C or other disor ders of the Liver, Disorders of the Gall bladder)?	☐ Yes ☐ No
	e) Diseases of the nervous system or mental disorders (e.g. Stroke, Epilepsy, fits or Fainting attacks, frequent head-aches, nervous breakdown, depression or other Mental or Psychiatric disorder)?	☐ Yes ☐ No
	f) Diabetes mellitus, Cancer or tumour of any kind, or any diseases of the blood, Glands, Spleen, Ears, Eyes or Skin?	☐ Yes ☐ No
	g) Unexplained night-sweats and / or persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands?	☐ Yes ☐ No
	h) Any other diseases or ailments not mentioned above?	☐ Yes ☐ No
	_____	
5.	Have your or any of immediate family members of the insured persons (Father, Mother, Brother, or Sister) have /had cancer, heart attack, or stroke prior to the age of 60 yrs?	☐ Yes ☐ No
6.	Have any of the insured persons ever underwent or been advised to have hospital treatment or surgery or were on any Medication, special diet, or treatment?	☐ Yes ☐ No
7.	Have any of the insured persons ever underwent or been advised to have a blood test for AIDS or an AIDS-related Condition?	☐ Yes ☐ No
8.	Have any of the insured persons ever received or now receive any personal accident, disability benefit, or disability-related payments?	☐ Yes ☐ No
9.	Have any of the insured persons smoked or used any substance or product containing Tobacco, Nicotine, marijuana, Narcotics, other habit forming drugs or been treated or advised in connection with Alcohol consumption or the taking of drugs?	☐ Yes ☐ No
	If yes, please state duration and average daily consumption and type: _____	
	If consumption is more than 15 Cigarettes a day, please attach medical reports.	
10.	Are any of the insured persons pregnant (for female only)? If yes, please state how many months, Please state if there was any pregnancy related complication during that persons' previous pregnancy/delivery.	☐ Yes ☐ No
11.	Do any of the insured persons participate or intend to participate in any hazardous sports or activities such as motor sports, climbing, parachuting, hang-gliding, or aviation except as a fare-paying passenger?	☐ Yes ☐ No
12.	Name, address and contact number of your family medical practitioner: _____	
13.	13. Please give details of any ailment, sickness or injury for any of the insured persons which may require medical attention.	
14.	If you answered "yes" to any of the questions numbered 2 to 10 above, please give complete details in table below.	

Sl. No	Name of insured	Illness (from above list) details	Date of treatment	Name/Address of Doctor	Period of treatment	Name / Address of Hospital	Present status
1							
2							
3							

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

Name:	Male	Female	Relationship with proposer

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Address:	

6. 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)	

7. DETAILS OF PREVIOUS/ EXISTING HEALTH INSURANCE POLICY

Do any of the proposed members have any previous or existing Health Insurance cover? If yes, provide following details

Name of Insured	Insurance Company)	Details of Coverage Source #	Expiring Policy No.	Date of Commencement of cover for first time**	Policy Expiration date*	Sum Insured ₹	Claim details	Claim free Bonus (if applicable)* in ₹

Details of Coverage Source IH Individual, FH - Family Health Policy, CC-Credit card / DC- Debit card Health policy, 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

8. ANY ADDITIONAL INFORMATION WISHED TO BE PROVIDED BY PROPOSER (Please use additional paper if required)

9. PREMIUM PAYMENT INFORMATION

Cash / Cheque / Draft Number/ PO		Date	DD/MM/YYYY	Amount ₹	
Amount (in words)					
Bank Name				Bank Branch	
Credit Card Number				Valid up to	DD/MM/YYYY

10. 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.

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- 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.

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/vmediary 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 totake or renew or continue an insurance in respect of any kind of risk relating to livesor 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 Intermediary Use Only (Documents submitted with this Proposal (Pl.'✓')					
Expiring policy with schedule	☐ Yes ☐ No	Premium Cheque:	Receipt Date: DD/MM/YYYY		
Original renewal notice attached	☐ Yes ☐ No	Medical Reports attached ☐ Yes ☐ No	Bill Amount in ₹. _____		
Medical Reports (if applicable)	☐ Yes ☐ No	Business of (Please '✓' in applicable box)	Rural	Social	Others_____

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IMPORTANT INFORMATION : Details of Pre-proposal Health Check-up reports required to be submitted along with the proposal form

Product Chosen and Sum Insured	Chola Hospital Cash Healthline (Revision)	For Chola MS Critical Healthline Insurance Sl. Rs. 3 Lakhs	For Chola MS Critical Healthline Insurance Sl Rs. 5 Lakhs	For Chola MS Critical Healthline Sum Insured Rs. 10 Lakhs
Package	Package 1	Package 2	Package 3	Package 4
MER	✓	✓	✓	✓
CBC	✓	✓	✓	✓
ECG	✓	✓	✓	✓
CUE	✓	✓	✓	✓
FBS	✓	✓	✓	✓
LFT		✓	✓	✓
RFT		✓	✓	✓
CXR			✓	✓
Lipid Profile			✓	✓
USG			✓	✓
TMT				✓

MER - Medical Examination Report
CBC - Complete blood Count
ECG - Electro Cardio Gram
CUE - Complete Urine Examination
FBS - Fasting Blood Sugar
LFT - Liver Function Test

RFT- Renal Function Test
CXR - Chest X-Ray
Lipid Profile
USG - Ultra Sono Gram
TMT - Treadmill Test

For pre-proposal health check-up appointment call:
1800 208 9100 (Tollfree)

PREMIUM CALCULATION (For Office Use only)

Sl.No.	Insured Name	Age	Chola MS Critical Healthline Insurance	Chola Hospital Cash Healthline (Revision)
	TOTAL			

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ACKNOWLEDGEMENT SLIP

PROPOSAL NO: CH_____

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