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

FLEXI MAX PROTECT

Product UIN: CHOHLIP21017V012122 / Proposal URN: Chola-MaxProtect-083-2020

(For Office Use Only)	Intermediary Name	Intermediary
Office	Employee Name	Customer ID
POSP Name		POSP PAN

1. INFORMATION ABOUT THE PROPOSER

Personal Details	Name: Mr./Mrs./Ms./Dr.:	
	Communication Address:	
	City:	District:
	State:	Pincode:
	Email ID:	Mobile No.
	Telephone No.:	STD Code:
	PAN:	GSTIN:
Nominee Details (Mandatory)	Nominee Name:	
	Nominee Relationship with the Insured:	
	Nominee Address:	
	*Nominee mentioned above is for the proposer. For other members covered under the policy, Proposer is deemed to be the nominee. In case the nominee is a minor, the guardian details will have to be provided.	

2. DETAILS OF COVERAGE (PLEASE TICK WHEREVER APPLICABLE)

Policy Tenure ☐ 1 Year ☐ 2 Years ☐ 3 Years	Survival Period: ☐ NIL days ☐ 30 days
Plan opted ☐ Plan A-10 CI ☐ Plan B-12 CI ☐ Plan C-20 CI ☐ Plan D-40 CI ☐ Plan E-50 CI	
Add-on Cover (on payment of additional premium): Medical Second Opinion-Add-on Cover ☐ Yes ☐ No	
Coverage required from am / pm of DD/MM/YYYY	to midnight of DD/MM/YYYY

3. INFORMATION OF THE PERSONS TO BE INSURED

Name of the Persons to be Insured	Geder (M/F)	Relationship with the Proposer	Date of Birth	Occupation	Weight in Kgs	Height in Cms	Base Sum Insured (₹)	ABHA number (14 digits)#
			DD/MM/YYYY					
			DD/MM/YYYY					
			DD/MM/YYYY					
			DD/MM/YYYY					
			DD/MM/YYYY					

Pre-Policy Medical check up is applicable for persons above 45 years of age and/or Sum Insured above Rs.25 Lakhs irrespective of age.
#Ayushman Bharat Health Account

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4. OPTIONAL COVERS (ON PAYMENT OF ADDITIONAL PREMIUM) (PLEASE TICK WHEREVER APPLICABLE)

Name of the persons to be insured	Double Protection Cover	Loss of Job Cover	Loss of Income for Self Employed
	☐	☐ SI (per month) **(₹)**	☐ SI (per month) **(₹)**
	☐	☐ SI (per month) **(₹)**	☐ SI (per month) **(₹)**
	☐	☐ SI (per month) **(₹)**	☐ SI (per month) **(₹)**
	☐	☐ SI (per month) **(₹)**	☐ SI (per month) **(₹)**
	☐	☐ SI (per month) **(₹)**	☐ SI (per month) **(₹)**

Additional documents to be submitted: Income tax return / Form 16 / Salary slips / Bank statement showing salary credits. Audited profit and loss statement for the business.
Loss of Income for Self Employed shall be 5% of Base Sum Insured or Rs. 10 Lakhs per month, whichever is lower
Loss of Job and Loss of Income for Self Employed can be opted only by and for the earning members under the policy upto the age of 65 years only.

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

Cheque */ Draft */PO* Number:	Date: DD/MM/YYYY
Transaction Reference No.	Transaction Reference Date: DD/MM/YYYY
Amount (in Rs.)	Amount (in words):
Bank Name:	Branch:

6. THE BELOW DETAILS ARE NECESSARY FOR PAYMENT OF CLAIM, REFUND OR CANCELLATION OF POLICY

Name of the Bank & Branch_____

_____

Bank Account No.:_____IFSC Code _____ MICR Code _____
(Please attach one cancelled cheque leaf)

7. HEALTH STATUS

Have you or any person proposed for insurance ever suffered from / are suffering from any of the following: Please tick 'YES' for insured wherever applicable and provide details.

1. Hypertension a) Duration b) Medications c) Dosage	Yes ☐ No ☐
2. Diabetes Mellitus History a) Type 1 or Type 2 b) Duration c) Medications d) Dosage e) Impaired Glucose Tolerance	Yes ☐ No ☐

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3. **Heart and Circulatory Conditions/Disorders:** chest pain, angina, high cholesterol/lipids, palpitations, congestive heart failure, coronary heart disease, heart attack, bypass surgery/angioplasty, valve disorder/ replacement, pacemaker insertion, rheumatic fever, congenital heart condition, conduction abnormalities, varicose veins, thrombosis, blood disorders etc.	Yes ☐ No ☐
4. **Brain/Nervous System/Psychiatric Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any other brain/nervous system Disease, Mental/Psychiatric disorder	Yes ☐ No ☐
5. **Cancer/Tumor:** Benign or Malignant tumor, Any growth/cyst, any cancer	Yes ☐ No ☐
6. **Respiratory Conditions/Disorders:** Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease COPD, Chronic cough, coughing of blood, etc or any other lung /respiratory disorder/ impairment of lung function	Yes ☐ No ☐
7. **Urinary Conditions/Disorders:** Renal Failure/Chronic renal disorder, Renal Transplant, Congenital disorders of renal system, End Stage Renal Disorder, Proteinuria	Yes ☐ No ☐
8. **Digestive Conditions/Disorders:** Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, inflammatory Bowel Disease unexplained weight loss or gain, eating disorder or any other gastro intestinal condition	Yes ☐ No ☐
9. **Autoimmune Disease** (Rheumatoid Arthritis/ SLE/ Ankylosing Spondylitis etc.)	Yes ☐ No ☐
10. **Obesity / Dyslipidemia / Genetic Disorders**	Yes ☐ No ☐
11. Do you consume tobacco products/cigarettes or drinks alcohol	
a. Tobacco / Gutkha consumption – No. of Packets per day	
b. Smoking – No. of Cigars/Beedi per day	
c. Alcohol	____ units of hard liquor per week __ glasses of wine per week __ ml of beer per week
12. Do you suffer from any chronic or long-term medical condition, or have any other disability/ Paraplegic/ Hemiplegic/ Quadriplegic abnormality or recurrent illness or injury or unable to perform not activities	Yes ☐ No ☐

If you answered 'Yes' to any of the above questions, give the details in the table below

Sl. No.	Name of the Persons to be Insured	Illness	Date of Treat-ment	Name / Address of Doctor	Period of Treatment	Name / Address of Hospital	Present Status
1							
2							
3							
4							
5							

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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. 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.

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

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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.

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.