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)	
POSP Name:	**POSP PAN:**

PROPOSAL FORM

Proposal URN: Chola-DB-Ret-174-2023

DIVYANG BIMA, CHOLA MS

UIN: CHOHLIP23216V012223

GUIDELINES FOR COMPLETION OF THE FORM:

- This policy is specially designed for Persons with Disability, Mental Illness and Persons with HIV/AIDS.
  a. Persons with Disability shall be covered if 40% or more disability is certified by the Medical Board appointed by the government for certifying Disability as per the Disability act 2016.
- Please answer all questions correctly and completely.
- Information for fields marked with asterisk (*) are mandatory.
- Only Indian Nationals can be covered under this policy.
- Only one policy can be purchased for this product across all insurers.
- Note: The Coverage proposed for Insurance is not covered until the proposal is accepted and premium is paid and the same is realized by Name of Insurance Company.

1. INTERMEDIARY DETAILS

Intermediary Name	
Intermediary Code	
Intermediary Contact Details	

2. PROPOSER DETAILS

Name		
Communication Address		
	City	State
	Pin-code	Landmark
Contact Details	Phone	Email
Profession	Salaried ☐ Self-Employed ☐ Others ☐ Details:_____	
Occupation and Nature of Business/Work		
PAN/Form 60/61		
Aadhar No.		
Date of Birth		
Gender	Male ☐ Female ☐ Other ☐	

3. COVERAGE DETAILS

Policy Type	Individual Basis
Policy Period	1 year

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

Period of Insurance	From DD/MM/YYYY to DD/MM/YYYY
Sum Insured	Rs.400,000/- ☐ Rs.500,000/- ☐
Coverage opted	Pre-existing HIV/AIDS ☐ Pre-existing Disability ☐ Pre-existing HIV/AIDS and Disability ☐
Waiver of Co-payment opted	Yes ☐ NO ☐

4. DETAILS OF THE PERSONS TO BE INSURED

S No	Name of the Insured	Nationality	Date of Birth	Age	Gender	Height in cm	Weight in Kg's	Occupation	Marital Status	Relationship with Proposer	ABHA Number (14 Digits)#

#Ayushman Bharat Health Account

5. NOMINEE DETAILS

Name	Date of Birth	Age	Relationship with Insured
Where nominee is a minor, give details of the Appointee			
Name	**Date of Birth**	**Age**	**Relationship with Insured**

6. PREVIOUS/EXISTING HEALTH DETAILS OF INSURED

Do you suffer from HIV/AIDS?	Yes ☐ NO ☐	If Yes, please enclose a recent certificate of your current CD4 count (within past 30 days)
Current CD4 count		
Has your CD4 Count gone below 500 in the past 4 years?	Yes ☐ NO ☐ If Yes when and How many times	
Do you suffer from any other Illness/disease related to/arising of/associated to HIV/AIDS?	Yes ☐ NO ☐	If Yes Please give details:
Do you suffer from any Disability as per the listed conditions mentioned below:	Yes ☐ NO ☐	If yes, please enclose Disability certificate mentioning percentage of disability wherever applicable

Disability	Percentage of Disability	Disability	Percentage of Disability
1. Blindness ☐		2. Muscular Dystrophy ☐	
3. Low vision ☐		4. Chronic Neurological conditions ☐	
5. Leprosy Cured persons ☐		6. Specific Learning Disabilities ☐	
7. Hearing Impairment (deaf and hard of hearing) ☐		8. Multiple Sclerosis ☐	
9. Locomotor Disability ☐		10. Speech and Language disability ☐	

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

11. Dwarfism ☐		12. Thalassemia ☐	
13. Intellectual Disability ☐		14. Haemophilia ☐	
15. Mental Illness ☐		16. Sickle cell disease ☐	
17. Autism spectrum disorder ☐		18. Multiple Disabilities including deaf/ blindness ☐	
19. Cerebral Palsy ☐		20. Acid Attack victim ☐	
21. Parkinson's disease ☐			

Please specify if multiple disabilities, locomotor disability, chronic neurological conditions, mental illness or specific learning disability

Please attach all past medical reports pertaining to disability, mental illness and/or HIV/AIDS

Do you suffer from any pre-existing illness other then Disability or HIV/AIDS mentioned above? Yes ☐ No ☐
If Yes, please specify details and the number of years you are suffering : _____

Do you have any other physical disability arising out of Illness/disease condition ?

Any other Previous medical details

S No	Name of the person to be Insured	Illness/Condition Name	Diagnosis Date	Date of last consultation	Treatment details	Present Status

7. PREVIOUS / EXISTING HEALTH INSURANCE POLICY DETAILS

Do any of the proposed members have any existing Health Insurance Cover? If Yes, provide following details

Policy No/ Application No.	Insurer Name	Period of Insurance (from-to)	Sum Insured	Claims lodged during the preceding years

Do you have the same policy from any one or other insurer? Yes ☐ No ☐
If Yes, Please share details below

Policy No/ Application No.	Insurer Name	Period of Insurance (from-to)	Sum Insured	Claims lodged during the preceding years

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)

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

9. PREMIUM PAYMENT DETAILS	
Name of Premium Payer	
Premium Payment frequency	☐ Annual Mode ☐ Half Yearly Mode ☐ Quarterly Mode ☐ Monthly Mode
Premium Amount (in INR)	
Instrument Type	Cash/ Cheque/ Debit Card/ Credit Card/ Others: Please Specify
Date DD/MM/YYYY	Cheque no
Bank Name	Bank Account number
IFSC Code	Branch Name

10. BANK ACCOUNT DETAILS FOR PROCESS OF REFUND	
Cheque will be issued in the name of the Proposer only	
In case of Cancellation of policy, if premium was paid through credit card the refund amount would be credited to Credit card account directly or refund will be paid through cheque. Please provide the following bank details and a copy of Cancelled Cheque if you opt for direct credit of refund / claim into your bank account (Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly.)	
Name of Account holder	
Cheque No	
Bank Name	
Branch Name	
Cheque Date	
Cheque Amount for Rs.	
Name as in Bank Account	
Bank Account No	
IFSC Code	
MICR Code	
Note : The Proposer agrees and undertakes to intimate in writing to **CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED** about any change in Bank account details. If ECS is selected, please submit the standing instruction form available at our branches.	
Date: DD/MM/YYYY Place:	Signature of Proposer

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

11. AML GUIDELINES

I/We hereby confirm that all premiums have been / will be paid from bonafide sources and no premiums 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 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.

12. AGENT'S DECLARATION

I _____ (Full name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/ Authorised employee of the Broker/ Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s),information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information / response(s) is/ are contained in this Proposal Form/ including Addendum(s), affidavits, statements, submissions, furnished/ to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the company as null and void and all premiums paid under the Policy may be forfeited to the company.

Date: DD/MM/YYYY

Signature of Agent :

Place:

License No :

13. DECLARATION AND WARRANTY ON BEHALF OF ALL THE PERSONS PROPOSED TO BE INSURED

I. I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.

II. 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 insurance company and that the policy will come into force only after full receipt to the premium chargeable.

III. I/We further declare that I/We 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.

IV. I/We declare and further consent to the company seeking medical information from any doctor or from a hospital who/which at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured / proposer and seeking information from any insurance company to which an application or insurance on the life to be assured/ proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

V. I/ We authorize the Company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory Authority.

VI. I/ We aware of premium loading, (if any declared above) for habit's &diseases as declared / mention by me/ us above.

VII. I/ We hereby agree to keep record of KYC details of all the individual members covered under the group insurance, and ensure to provide the details of beneficiaries to the company as and when required.

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.

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

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.

14. VERNACULAR DECLARATION

**Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language.

(Note : The below must be witnessed by someone other than the Advisor/ Employee of the Company)

I/ We certify that the product applied for me/ us and the contents of the Proposal Form have been clearly explained to me/ us and I/ We have fully understood them. I/ We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/ us. I, (Full name of the Witness) _____ (Relation with proposer) _____ adult and inhabitant of (City) _____ and residing at _____ do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the Insurance policy from **CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED** to the proposer and he/ she/ they have understood the same. I/ We declare that whatever I/ We have stated herein above is true and correct to the best of knowledge and belief.

Date: DD/MM/YYYY Place:

Signature of the Witness Signature / Thumb Impression of Proposer

STATUTORY WARNING
Section 41 of Insurance Act, 1938

As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited as follows:

(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 from

UMRN: For office use only **Date:** DD MM YYYY

Sponsor Bank Code: CITI000PIGW

Utility Code: CITI00002000000037

Tick (✓)	
Create	✓
Modify	
Cancel	

I/We hereby authorise: Cholamandalam MS General Insurance Company Ltd.

To debit (tick): SB/CA/CC/SBNRE/SB-NRO/Other

Bank a/c number

With bank

IFSC

or MICR

an amount of Rupees: Amount in Words

₹

Frequency ☒ Mthly ☒ Qtly ☒ H-Yrly ☒ Yrly ☑ As & when presented

Debit Type ☒ Fixed Amount ☑ Maximum Amount

Reference 1

Phone No.

Reference 2

Email ID

I agree to the debit of mandate processing charges by the bank whom I am authorising to debit my account as per latest schedule of charges of the bank.

PERIOD

From

To

1. Signature of Primary Account holder
Name as in Bank Records

2. Signature of the Account holder
Name as in Bank Records

3. Signature of the Account holder
Name as in Bank Records

• This is to confirm that the declaration has been carefully read, understood and made by me/us. I am authorising the user entity/corporate to debit my account • I have understood that I am authorized to cancel/amend this mandate by appropriately communicating the cancellation/amendment request to the user entity/corporate or the bank where I have authorised the debit.