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 5544 | 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

PROPOSAL FORM

FLEXI HEALTH

Product UIN: CHOHLIP20107V011920 / Proposal URN: Chola MS-Flexi Health-Ret-062-2019

(For Office Use Only)	Agent Name:	Agent Code:	Sl No:

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		☐ Passport ☐ DL No.:	
	Mobile No: +91	Tel (O) +91	Extn:	Tel (R) +91
	PAN: (Mandatory)	Aadhar No.: (Optional)		
	GSTIN:	E Insurance Account No. (if available):		
	Email ID:			
Address	Door / Flat No:	Building No / Name:		
	Street Name:	Landmark:		
	Sub Area / Village:	Area / Tehsil:		
	City:	District:	PIN:	State:

Existing CHOLA MS Customer: ☐ Yes ☐ No | If Yes, Provide Policy Number:

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 _____

2. DETAILS OF COVERAGE

Policy Type: ☐ Individual ☐ Family Floater	Policy Tenure ☐ 1 Year ☐ 2 Years ☐ 3 Years
Coverage required from am / pm of DD/MM/YYYY	to midnight of DD/MM/YYYY

3. INFORMATION OF THE PERSONS TO BE INSURED

Sl. No.	Name of the Persons to be Insured	Geder (M/F)	Relationship with the Proposer	Date of Birth	Sum Insured	Weight in Kgs	Height in Cms	Marital Status	Occupation
				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
- Proposals for members above 50 years of age will be processed only with a medical check up

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4. NOMINATION (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)

Nominee Name:	Nominee Relationship with the Insured:
Nominee Address & Contact details:	
Nominee mentioned above is for the proposer. For other members covered under the policy, proposer is deemed to be the nominee.	

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 ☐
Do any of the persons proposed for insurance suffered from any of the following ailments / diseases?	
High Blood Pressure	Yes ☐ No ☐
Diabetes / Sugar	Yes ☐ No ☐
Chest Pain or any other Heart Disease	Yes ☐ No ☐
Stroke / Epilepsy / Disorder of Brain or Nervous System	Yes ☐ No ☐
Asthma / Tuberculosis	Yes ☐ No ☐
Stomach or Duodenal ulcer of any kind or ulcer of any kind	Yes ☐ No ☐
Disorders of Gall Bladder, Liver, Stomach or Intestines, Hernia of any kind	Yes ☐ No ☐
Kidney / Bladder / Prostate disorder	Yes ☐ No ☐
Disorder of the joints / Arthritis / Rheumatism or any pain	Yes ☐ No ☐
Cancer / Tumour / Growth of Cyst of any kind	Yes ☐ No ☐
Varicose Veins / Varicose Ulcers	Yes ☐ No ☐
Any other illness or disease	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							

6. 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 Rs.	Claim Details	Claim free Bonus (if applicable)* in Rs.
				DD/MM/YYYY	DD/MM/YYYY			
				DD/MM/YYYY	DD/MM/YYYY			

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				DD/MM/YYYY	DD/MM/YYYY			

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

7. PREMIUM PAYMENT INFORMATION (*Cheque / Draft to be drawn in favour of "Cholamandalam MS General Insurance Company Limited")

PREMIUM PAYMENT MODE (please tick the mode selected)

☐ Single payment Mode ☐ Annual Mode ☐ Half Yearly Mode ☐ Quarterly Mode ☐ Monthly Mode

In the event of opting for other than single payment mode, Premium to be paid is as below with the filled in proposal form:

- Monthly Mode – Premium applicable for first 3 Months including GST
- Quarterly Mode – Premium applicable for the first Quarter including GST
- Half-Yearly Mode – Premium applicable for the first Half of the policy year including GST
- Annual Mode – Premium applicable for the first policy year of the policy period including GST

(For Office Use Only)

Single Premium Payment Mode	**Other than Single Premium Payment mode**
Premium Payable for the policy tenure (excluding GST) Rs.	Premium Payable for the policy tenure (excluding GST) Rs.
GST Rs.	Modal Premium Payable: Rs. GST: Rs.
Premium (including of GST) Rs.	Modal Premium (including of GST) Rs.

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

8. 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.

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.

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

Payment Declaration:

I authorize Cholamandalam MS General Insurance Company Limited to debit my account with the due premium and the additional charges as applicable for revival of policy, in the event of default of premium on the due date till expiry of the Grace Period to ensure continuity of cover.

I authorize Cholamandalam MS General Insurance Company Limited to debit my account with any due premiums and the additional charges as applicable, on the following due date of earlier default of premium and additional charges for revival.

I authorize Cholamandalam MS General Insurance Company Limited to use Account details and IFSC code declared in the Debit Mandate for payment of any claim under the policy.

I confirm to Cholamandalam MS General Insurance Company Limited to utilise the Debit Mandate form signed and submitted by me for the purpose of Auto renewal of the policy. ☐ Yes ☐ No

Signature / Thumb Impression of Proposer	Date: DD/MM/YYYY	Place:

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 Tollfree No:1800 208 5544.
Please get your queries clarified before signing the proposal form.

UMRN: F o r o f f i c e u s e o n l y **Date:** D D M M Y Y Y Y

Sponsor Bank Code | Utility Code:

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

Or ☐ Until Cancelled

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.