RELIGARE Values that bind | Health Insurance

Ab Health Hamesha

Application Form - 'GROUP CARE SCHEME'

(Group Scheme for members of Samagra Jain Shwetambar Murtipujak Tapagachh Shree Mahasangh)

Proposal No. Group Care Scheme.....

For Office Use Only

Intermediary Details

Booking Account Code : Booking Account Name :

Partner RM Code : Partner Branch Code :

Customer ID :

Proposer Details

Mr. Ms. Gender : M F

Name : (First Name) (Last Name)

Address : ?

Landmark :

City : State :

Pin Code : Date of Birth : / / (DD/MM/YYYY) Marital Status : Single Married

Landline : - Mobile :

E-mail :

PAN : (Mandatory for premium above ₹49,999) Nationality :

Mother's Maiden Name :

Occupation :

Nominee Details

Name :

Date of Birth : / / (DD/MM/YYYY) Relationship with Proposer :

Appointee name : Mr. Ms.

Appointee DOB : / / (DD/MM/YYYY) (Only where the Nominee is of Age 18 years or less)

In event of the death of the proposer any payment due under the policy shall become payable to the Nominee proposed in this form. The receipt of the proceeds by the Nominee would be sufficient discharge to the Company.

Policy Details

Sum Insured (Group Care Scheme) : Tenure : 1 Year

Details of the Person to be Insured (Including Proposer)

Name	Group Care Scheme	Date of Birth	Gender	Height & Weight		Relationship with Proposer
Insured 1 :		(DD/MM/YY)	M F	cms	kgs	
Insured 2 :		(DD/MM/YY)	M F	cms	kgs	
Insured 3 :		(DD/MM/YY)	M F	cms	kgs	
Insured 4 :		(DD/MM/YY)	M F	cms	kgs	

Premium Payment Information

Payment By : Cheque/Demand Draft/Card (Strike out whichever is not applicable) Cheque/Demand Draft No./Transaction ID :

Date : / / (DD/MM/YYYY) Amount (₹) : _____ Premium Amount (₹) : _____

Bank Name : Sources of Funds : Salary Business Others (if others, please specify)_____

In case of payment through Cheque/Demand Draft, the instrument should be drawn in favour of **"Religare Health Insurance Company Ltd."**

Ver: Nov/17

Religare Health Insurance Company Limited
Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019 Corresp. Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Rd., Sec-43, Gurugram-122009 (Haryana)
Website: www.religarehealthinsurance.com E-mail: customerfirst@religarehealthinsurance.com Call us: 1800-200-4488 | 1860-500-4488 Fax: 1800-200-6677
CIN: U66000DL2007PLC161503 UIN: IRDA/NL-HLT/RHI/P-H/V.I/254/13-14 IRDA Registration No. - 148

Medical/Lifestyle Related Information

Particulars	Insured 1	Insured 2	Insured 3	Insured 4
Does any proposed insured currently or in past Diagnosed / Suffered / Treated / Taken Medication for any of the following conditions: If yes, please provide details in the additional information section below:				
1. Cancer, tumor, polyp or cyst	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
2. Any heart disease or disorder, chest pain or discomfort, irregular heartbeats, palpatations or heart murmur	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
3. Hypertension / High Blood Pressure(BP)/ High Cholestrol	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
4. Asthma / Tuberculosis (TB) / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease ?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
5. Thyroid disease / Cushing's disease / Parathyroid Disease / Addison's disease / Pitutiary tumo r/ disease or any other disorder of Endocrine system ?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
6. Diabetes Mellitus / High Blood Sugar / Diabetes on Insulin or medication	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
7. Motor Neuron Disease / Muscular dystrophies / Myasthnia Gravis or any other disease of Neuromuscular system (muscles and/or nervous system)	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
8. Stroke / Paralysis / Transient Ischemic Attack / Multiple Sclerosis / Epilepsy / Mental-Psychiatric illne ss/ Parkinsonism / Alzeihmer's / Depression / Dementia or any other disease of Brain and Nervous System?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
9. Cirrhosis / Hepatitis / Wilson's disease / Pancreatitis / Liver disease / Crohn's disease / Ulcerative Colitis / Piles or any other disease of Mouth, Esophagus, Liver, Gall bladder, Stomach or Intestines or any other part of Digestive System?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
10. Kidney Stones/ Renal Failure/ Dialysis / Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
11. HIV/SLE / Arthiritis / Scleroderma / Psoriasis / bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin.	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
12. Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses)?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
13. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please provide the frequency & amount consumed	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
14. Any other disease / health adversity / injury/ condition / treatment not mentioned above?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____
15. Has any of the Proposed to be Insured been hospitalized / recommended to take investigations / medication or has been under any prolonged treatment / undergone surgery for any illness / injury other than for childbirth / minor injuries?	Y N Since_____	Y N Since_____	Y N Since_____	Y N Since_____

Note: The Company shall reject Your proposal and refund the premium amount (after deducting cost of medical tests, if any) in case of incompleteness or any discrepancy highlighted or any other reason.

Details of Previous or Existing Health Insurance

Please fill the following details with respect to health insurance proposals/policies with the Company or any other insurance companies

Details	Insured 1	Insured 2	Insured 3	Insured 4
Have any of the person(s) to be insured ever filed a claim with their current/previous insurer? If Yes, please provide details on a separate sheet	Y N	Y N	Y N	Y N
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	Y N	Y N	Y N	Y N
Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company?	Y N	Y N	Y N	Y N

Declaration

a. 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.

b. 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.

c. I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured / proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

d. I declare that I consent to the company seeking medical information from any doctor or 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.

e. 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 any Governmental and / or Regulatory authority.

Date : __ __ / __ __ / __ __ __ __ (DD/MM/YYYY)

Signature of the Proposer :_____

Place : _____

(On behalf of all the persons to be insured under the Policy)

મેડીકલ ઇન્ફોર્મેશન શીટ માં ૧-૧૫ રોગોના નામ અંગ્રેજી ભાષામાં છે, તેનું ગુજરાતી અનુવાદ

૧) કેન્સર કોઇપણ પ્રકારના, કેન્સરની ગાંઠ જેવા રોગ

૨) હૃદયને લગતાં રોગ, છાતીનો દુખાવો, હૃદય કે નાડીના ધબકારામાં અનિયમિતતા જેવા રોગ

૩) બ્લડ પ્રેશર, કોલેસ્ટ્રોલ ને લગતા રોગ

૪) શ્વાસ/ટી.બી./એલર્જી/અસ્થમા જેવા ફેફ્સાને લગતા રોગો

૫) થાઇરોઇડ તેમજ બીજી ગ્રંથીઓને લગતા રોગો

૬) ડાયાબીટીસ અને તેતે લગતા રોગો

૭) મગજ અને નસ તેમજ સ્નાયુને લગતા રોગો

૮) પેરાલીસીસ - લકવા - કંપવા - ડીપ્રેશન તેમજ ચેતાતંત્રને લગતા રોગો

૯) લીવર, પેન્ક્રીયાસ(સ્વાદુપિંડ) આંતરડાના રોગો, (પાઇલ્સ, મુખ, અન્નનળી, પિત્તાશય હોજરી અને પાચનતંત્રને લગતા રોગો)

૧૦) કીડની, પથરી, ડાયાલીસીસ, પ્રોસ્ટેડ, ગર્ભાશયને લગતા રોગો

૧૧) એઇડ્સ, વા, લોહીની ઉણપ, બોનમેરો, ચામડીને લગતા રોગ

૧૨) આંખ, કાન, નાક, ગળા ને લગતા રોગો

૧૩) દારૂ, તમાકુ, ગુટખા, પાન જેવી આદતોની માહિતી

૧૪) કોઇપણ જાતનો અકસ્માત તેમજ ઉપરના રોગો સિવાયની માહિતી

૧૫) કોઇપણ પ્રકારની ભૂતકાળમાં કરાવેલી સર્જરી અથવા હોસ્પીટલમાં દાખલ થયા હોય તો તે અથવા લાંબી બિમારીની સારવાર લીધી હોય અથવા લેતા હોય તો તેની માહિતી