Health Care Insurance

Proposal form

Completing the Proposal form

1. This proposal must be fully complete including all the required documents
2. It is a duty of prosper to disclose all the material facts, if it would influence the judgement of a prudent insurer.
3. Insurance is based on utmost good faith and in the absence of such good faith, Solarelle may treat your policy as if it never existed if the misrepresentation or your non-compliance with your duty of disclosure was fraudulent.
4. Solarelle assure for the Personal or Sensitive Information/s that we collect are secured from the proposer is secured. Without such Information Solarelle may not be able to process your application, administer your policy or assess your claims.
5. Solarelle may obtain Information from government offices and third parties to assess a claim in the event of loss or damage.

PROPOSER INFORMATION

Name of the Proposer: _____

Address: _____ Postal Code: _____

ID/Passport No: _____ Email: _____

Telephone: _____ Fax: _____ Company Registration No: _____

Nature of Business: _____

Company: _____

Nationality: _____

Marital Status: _____

Contact Name: _____

Position: _____

Mobile Number _____

Email _____

ID Proof Type: Passport ☐
National Identity Card ☐
Driving License ☐
Other (Provide Detail) ☐

ID Proof No: _____

Annual Income: _____

Detail: _____

SUBJECT MATTER

Cover required:

Plan: Standard ☐
Exclusive ☐
Premium ☐

Policy Period: 1 Year ☐
Other ☐ _____

Proposed Policy Period: From: _____ To: _____

Type: Individual ☐
Floater ☐

Proposed Insured(s) Details

Insured #1:
Name: _____
Height:_____cm Relationship: _____ Date of Birth: _____
Weight:_____kg Gender: Male☐ Female☐ Sum Insured: _____
Occupation: _____ CI Sum Insured: _____

Insured #2:
Name: _____
Height:_____cm Relationship: _____ Date of Birth: _____
Weight:_____kg Gender: Male☐ Female☐ Sum Insured: _____
Occupation: _____ CI Sum Insured: _____

Insured #3:
Name: _____
Height:_____cm Relationship: _____ Date of Birth: _____
Weight:_____kg Gender: Male☐ Female☐ Sum Insured: _____
Occupation: _____ CI Sum Insured: _____

Insured #4:
Name: _____
Height:_____cm Relationship: _____ Date of Birth: _____
Weight:_____kg Gender: Male☐ Female☐ Sum Insured: _____
Occupation: _____ CI Sum Insured: _____

Insured #5:
Name: _____
Height:_____cm Relationship: _____ Date of Birth: _____
Weight:_____kg Gender: Male☐ Female☐ Sum Insured: _____
Occupation: _____ CI Sum Insured: _____

Insured #6:
Name: _____
Height:_____cm Relationship: _____ Date of Birth: _____
Weight:_____kg Gender: Male☐ Female☐ Sum Insured: _____
Occupation: _____ CI Sum Insured: _____

Please paste stamp sized photograph(s) in sequence (Insured 1, Insured 2 and so forth) as specified in section 3 – Proposed insured(s) details

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6

****Family Floater Policy will have same Sum Insured for all members**
****Designation/Exact nature of duties**
****Critical Illness Sum Insured would be 50% or 100% of the Sum Insured subject to a minimum of MVR xxxx.xx and maximum of MVR xxxxxxx.xx and the same rule is applicable to all members**

NOMINEE DETAILS

In the event of death of an Insured Person any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Prosper. Nominee for any of the persons proposed to be insured shall be the proposer.

Nominee Name	Relationship	Address of the Nominee

*If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship	Address of the Nominee

EXISTING/PREVIOUS INSURANCE DETAILS

Is the proposer or the persons proposed, already insured under a plan with Solarelle Insurance Private Limited or any other insurance company? Yes☐ No☐
If YES, please indicate below Policy/Application number(s), mentioning application number in case of pending proposal.

Since when are you continuously insure?_____
Do you want us to consider these details for continuity? Yes☐ No☐

Policy No./Application No.	Insurer	Period of Insurance		Sum Insured (MVR)	Claims lodged during the preceding years
		From	To		

***Note: Continuity of benefits shall NOT be considered If the above question of want of continuity is not replied affirmative, details are not provided and Portability form and relevant supporting documents are not submitted.**

Medical and Lifestyle Information MEDICAL AND LIFESTYLE INFORMATION

Medical History: Please answer the below mentioned questions Yes or No ONLY:

	A) Has any of the person proposed to be insured ever suffered from/are currently suffering from any of the following?	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6
1	High or low blood pressure, Chest Pain, or any other cardiac disorder?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
2	Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
3	Ulcer(Stomach/Duodenal), Live, gall bladder disorder or any other digestive tract disorder?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
4	Kidney Failure, Stone in kidney or urinary tract, Prostate disorder or any other kidney/ urinary tract disorder ?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
5	Stroke, Epilepsy (fits), Paralysis or any other nervous system (Brain, Spinal cord, etc) Disorder?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
6	Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder ?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

7	Tumor (Swelling)-benign or malignant, any external ulcer/growth/cyst/mass anywhere in the body ?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
8	Arthritis, Spondylosis or any other disorder of the muscle/bone/joint ?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
9	Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error) ?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
10	HIV/AIDS or sexually transmitted diseases or any immune system disorder ?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
11	Anaemia, Leukaemia, Lymphoma or any other blood/lymphatic system disorder ?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
12	Psychiatric/Mental illnesses or Sleep disorder ?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
13	Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/Breast disorder ?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

B) Has any of the persons proposed to be insured;		1	2	3	4	5	6
14	Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
15	Been under any regular medication (self/ prescribed)?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
16	Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
17	Undertaken any surgery or a surgery been advised and have surgery still pending?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
18	Suffered from any other disease/illness/accident/injury other than common cold or viral fever?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
19	Is any of the insured persons pregnant? If yes, please mention the expected date of delivery: _____	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
20	Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

C) Name and details of Illness/Medicine/Surgery/Diopter grade (for questions answered YES in section A & B	Exact diagnosis	Diagnosis date	Date of last consultation	Treatment In/Outpatient and details of treatment given	Doctor/Hospital Name & Phone No:
Insured Person 1:					
Insured Person 2:					
Insured Person 3:					
Insured Person 4:					
Insured Person 5:					
Insured Person 6:					

D) Name, address, qualification and contact details of the family doctor. If ANY:	
Name:	
Qualification:	
Address:	
Postal Code:	Mobile Number:
Phone No:	Email ID:

E) Does any person proposed to be insured smoke or consume Pan Masala/Alcohol. If YES, please indicate the name and quantity per week	Alcohol	Smoke	Pan Masala	Others
Insured Person 1:				
Insured Person 2:				
Insured Person 3:				
Insured Person 4:				
Insured Person 5:				
Insured Person 6:				

F) In respect of any of the persons proposed to be insured:	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6
Has any application for life, health, hospital daily cash or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

Please enclose with this Proposal a copy of Medical Documents, ID Proof Copy(ies), Photographs and any additional information to the vessel and operation which you feel may be useful to the Company in assessing the risk

Politically Exposed Person (PEP) Declaration

Are you, or any beneficial owner, director, authorised signatory, or person acting on behalf of the proposer, a Politically Exposed Person (PEP), or a close associate or immediate family member of a PEP?

☐ Yes ☐ No

If "Yes", please provide full details: _____

Declaration

I/We hereby declare and warrant that the statements and particulars given in this Proposal Form are true, complete, and accurate to the best of my/our knowledge and belief, and that no material facts have been withheld or misrepresented.

I/We understand and agree that this Proposal Form, together with any supplementary information provided, shall form the basis of and be incorporated into the contract of insurance between myself/ourselves and the Insurer.

I/We further undertake to notify the Insurer immediately of any material alteration to the information provided before the commencement of the insurance or during the currency of the policy.

I/We acknowledge that any non-disclosure, misrepresentation, or fraudulent statement may render the policy voidable and may result in denial of claims.

I/We consent to the Insurer collecting, obtaining, verifying, and sharing relevant information and documents from or with reinsurers, loss adjusters, brokers, regulatory authorities, other insurers, or any other relevant parties for underwriting, risk assessment, claims handling, fraud prevention, recovery proceedings, and policy administration purposes.

(No insurance cover is provided until the above proposal is accepted and details of cover are confirmed in writing by Solarelle Insurance Private Limited)

Name of proposer: _____

Date: _____ Signature of proposer Company Stamp:

Office use only

Intermediary Premium / Rate: Special Condition: Broker / Agent / Sales Code: