hrsmarth51@gmail.com
infosmarth51@gmail.com

SMART HEALTH AND EDUCATION CARE FOUNDATION

Administrative Office- 2nd Floor, Mehra Estate,
CTS Number 68, L.B.S. Marg Vikhroli (West) Mumbai Maharashtra-400079

SELF HELP ACCIDENTAL PROTECTION PROGRAM

ENROLLMENT / APPLICATION FORM

Program Name: Self Help Accidental Protection Program

PLAN OPTION

□ PLAN A – BASIC PROTECTION

One-Time Contribution: ₹5,000/-

Proposed Accidental Protection Benefit: Up to ₹5,00,000/-

□ PLAN B – PREMIUM PROTECTION

One-Time Contribution: ₹10,000/-

Proposed Accidental Protection Benefit: Up to ₹10,00,000/-

Age Eligibility: 5 Years to 60 Years

Note: Benefits are subject to the final approved scheme terms, eligibility conditions, exclusions, documentation, and applicable laws/regulations.

2. APPLICANT / MEMBER DETAILS

Full Name: _____

Father / Husband / Guardian Name: _____

Date of Birth: ____ / ____ / _____Age: _____ Years

Gender: ☐ Male ☐ Female ☐ Other

Mobile Number: _____

Email ID: _____

Aadhaar / Government ID Type: _____ID Number:_____

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Full Address : _____

District_____State: _____PIN Code: _____

NOMINEE DETAILS

Nominee Name: _____

Relationship with Member/Insured: _____Date of Birth / Age: _____

Gender: ☐ Male ☐ Female ☐ Other

Mobile Number: _____Address: _____

_____

Nominee Aadhaar/PAN No. (Optional): _____

Nominee Share (%): _____

IN CASE OF MINOR

Nominee Guardian/Appointee Name: _____

Address_____

Relationship with Minor Nominee: _____

Guardian Date of Birth: _____/_____/_____Guardian Mobile No.: _____

CONTRIBUTION DETAILS

Selected Plan:

☐ Plan A – Rs. 5,000/- Proposed Benefit: Up to Rs. 5,00,000/-

☐ Plan B – Rs. 10,000/-Proposed Benefit: Up to Rs. 10,00,000/-

Payment Mode:

☐ Cash ☐ UPI ☐ Bank Transfer ☐ ChequeTransaction

Receipt No.: _____Date of Payment: ____ / ____ / _____

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DECLARATION BY APPLICANT/GUARDIAN

We hereby declare that the information provided in this form is true and correct to the best of my/our knowledge.I/We understand that:This form is an application/enrollment request for the proposed Self Help Accidental Protection Program.The proposed benefit is subject to the final approved terms and conditions of the program. Accidental protection benefits are payable only for covered events as defined in the applicable scheme/policy documents.All exclusions, waiting periods, age conditions, claim procedures, documentation requirements, and other terms shall apply as per the final approved program documents. Payment of the one-time contribution does not automatically guarantee payment of any claim unless the applicant is accepted and covered under the applicable approved arrangement.The Foundation may require identity, age, nominee, medical, accident, police, hospital, or other documents for verification and claim processing.The applicant/guardian agrees to provide accurate information and authorizes verification of the submitted details for enrollment and claim administration.The program shall operate subject to applicable laws, regulations, approvals, and the final terms issued by the authorized implementing entity/insurer, wherever applicable.

Applicant / Guardian Signature: _____

Name: _____

Date: ____/____/_____ Place: _____

FOR OFFICE USE ONLY

Application No.:_____ Member ID:_____

Plan Selected: _____ ☐ Plan A ☐ Plan B

Documents Verified: ☐ Yes ☐ No

Application Status: ☐ Approved ☐ Pending ☐ Rejected

Authorized Officer Name: _____

Signature: _____ Date: _____

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SMART HEALTH AND EDUCATION CARE FOUNDATION MUMBAI

Acknowledgement / Receipt Received from Mr./Ms. _____

Amount:_____ Plan: _____

_____Application / Receipt No.: _____

Date: ____/ ____/ _____

This receipt acknowledges the amount received for enrollment/application processing under the proposed Self Help Accidental Protection Program. Final benefits remain subject to approved program terms and applicable conditions.

Authorized Signature: _____

Foundation Seal