

(CCP / ECHC)

Please select the appropriate option and fill the details accordingly. Please If Yes or No

Any addition / deletion in the family information form can be done by separate application as and when applicable along with valid proof / support documents.

* Refer our healthfriend guide for centers and rules and regulation

<input type="checkbox"/>	SPOUSE (Wife/Husband)												
			LAST NAME					FIRST NAME				MIDDLE NAME	
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Age: <input type="text"/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F
<input type="checkbox"/>	CHILD 1 (Unmarried)												
			LAST NAME					FIRST NAME				MIDDLE NAME	
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Age: <input type="text"/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F
<input type="checkbox"/>	CHILD 2 (Unmarried)												
			LAST NAME					FIRST NAME				MIDDLE NAME	
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Age: <input type="text"/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F

<input type="checkbox"/>	SELF FATHER												
			LAST NAME					FIRST NAME				MIDDLE NAME	
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Age: <input type="text"/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F
<input type="checkbox"/>	SELF MOTHER												
			LAST NAME					FIRST NAME				MIDDLE NAME	
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Age: <input type="text"/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F

<input type="checkbox"/>	SPOUSE FATHER												
			LAST NAME					FIRST NAME				MIDDLE NAME	
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Age: <input type="text"/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F
<input type="checkbox"/>	SPOUSE MOTHER												
			LAST NAME					FIRST NAME				MIDDLE NAME	
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Age: <input type="text"/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F

Beneficiary Details

I _____ having paid for the service offered by your company, would like to avail of the preventive health checkup myself / hereby authorize below mentioned family member of the preventive health checkup package.

Name of the Beneficiary			
Sex	<input type="checkbox"/> M / <input type="checkbox"/> F	Date Of Birth	<input type="text"/>
Address of Beneficiary			
Contact No.			

I wish to avail the checkup on / / 2010 or / / 2010

I am aware that in case the above mentioned dates are not available, Indus Health Plus (P) Ltd. will allocate an available date. I understand that the company can at its discretion give me a second opportunity for checkup. It is my responsibility to get an appointment for the customer / customer distributor health checkup package from the office of Indus Health Plus (P) Ltd. and submit the annexure for the same. I am aware of the tests included in the package and that some tests are centre dependent.

Please tick the appropriate package and centre mentioned below

<input type="checkbox"/> Cardiac Care Health Checkup Package (CCP) 1 Medical Checkup by Doctor 2 Laboratory Workup 3 Chest X-ray 4 Electro Cardiogram 5 2D Echo Cardiography (Doppler Study of Heart) 6 Total Body Fat Percentage 7 CT Calcium Scoring 8 CT Coronary Angiography (Heart) 9 Counselling by Physician	<input type="checkbox"/> Exclusive and Comprehensive Health Checkup Package (EHC) 1 Medical Checkup by Doctor 2 Laboratory Workup 3 Chest X-ray 4 Electro Cardiogram 5 2D Echo Cardiography (Doppler Study of Heart) 6 Total Body Fat Percentage 7 Gynaecology Consultation 8* Pap Smear / TVS, USG (For women above 40 yrs.) 9 Ultra Sonography of Abdomen and Pelvis 10 Pulmonary (Lungs) Function Test 11* Screening Audiometry Test 12 Bone Mineral Densitometry (BMD) 13 a) CT Scanogram of Lumbar spine b) CT Scanogram / X-ray (If CT is cancelled) of Cervical Spine 14 Sono Mammography (For women above 30 yrs.) 15 Ophthalmology Checkup 16 CT Calcium Scoring 17 CT Coronary Angiography (Heart) 18 CT Screening of Carotid Arteries (Neck) 19 CT Screening of Intracranial Vessels (Brain) 20 CT Brain - Contrast 21 Counselling by Physician
Plus Silver Healthfriend Card Worth Rs.2500/-	
*Center dependant	

Cardiac Care Health Checkup Package (CCP) <input type="checkbox"/> NM Medical - Health 360, Marine Lines <input type="checkbox"/> NM Medical, Boriwali <input type="checkbox"/> Insight Imaging Centre, Chembur	Exclusive & Comprehensive Health Checkup Package (EHC) <input type="checkbox"/> NM Medical - Health 360, Marine Lines <input type="checkbox"/> NM Medical, Boriwali <input type="checkbox"/> Insight Imaging Centre, Chembur
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The package mentioned above cannot be split between two or more people.

CT of any abnormality detected in X-rays / USG will be done if necessary and if recommended by our Radiologist/ Counselling Doctors. The tests in the package are conducted as a screening procedure for early detection. Some tests may not be conducted if the person receiving the package, reports with any medical contra-indication (i.e. conducting the test/s is not advisable in the opinion of the Doctor conducting the test) or with a known medical history. The CT tests included in the package are recommended for people above the age of 35 yrs or with at least one of the following Risk Factors: A) Family history, B) Smoking for more than 10 yrs, C) Diabetes, D) BP problem / Hypertension, E) Dyslipidemia (elevated cholesterol / triglyceride levels), F) Stressful life styles G) Obesity. The CT Scan will be aborted in case the beneficiary does not have a stable Pulse Rate before the procedure or has any known contra-indication for injection of contrast / Dye etc. **CT Scanning is not recommended for pregnant and nursing women and will not be done.**

UNDERTAKING

- 1) That I am at least 18 yrs. of age and have carefully read and understood the Rules and Regulations of the Company and the contents of the Undertaking OR that the Rules and Regulations and the contents of this Undertaking have been explained to me in the language that I understand.
- 2) I undertake that I shall abide by the Rules and Regulations of the Company and that I fulfill the terms and conditions of becoming a Customer (C) or a Customer Distributor (CD) of the Company
- 3) I undertake not to claim any refund of the down payment or the price paid by me to the Company for any reason whatsoever after the expiry of the refund period.
- 4) I will not oversell nor give false promises or hopes to my prospective customers and will take personal responsibility for any and all complaints from my customers and downline. I shall also ensure that my prospective customers are made to attend the company seminar before requesting them to join.
- 5) I have been explained and am now aware of the risk factors and have gone through the relevant documents.
- 6) I have also been made aware that the incentive payment shown in the Rules and Regulations are the maximum incentive payable
- 7) The information filled by me in the form is true and correct and I take full responsibility for the same.
- 8) I have signed this Undertaking voluntarily and am doing so without being under any undue influence, misrepresentation or coercion.
- 9) I am aware that I am buying the Customer/Customer Distributor Package only and the incentive as per Business Plan cannot be earned by me if I am not successful in my distribution and that the company pays incentive only as per Business Plan which can fluctuate depending on the company's turnover.
- 10) I am aware that the company does not make any other payment other than what is mentioned in the Business Plan. I am further aware that the Company is not liable to compensate me for any expenses incurred by me for development of downline including holding of seminars. The company doesn't pay any salary to any CD and therefore the CD is not an employee of the company.
- 11) I understand that I am not supposed to pay any money to any CD who is a part of my upline and downline. I also understand that any money so paid by me will be at my risk and cost and shall not create any liability against the Company.

Witness ID _____ Witness Name _____ Signature _____

Date _____ Signature of Customer and Customer Distributor _____

For Office Use Only	Appointment No. <input type="text"/>	Signature of Authorised Person _____
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IMPORTANT TERMS AND CONDITIONS

- A) INTERESTS AND CLAIMS IN THE COMPANY:** The Customer / Customer Distributor (herein after referred to as CD and more specifically defined in the Rules and Regulations) or any other CD to whom the Package was marketed by him, will not have any right, title, interest or claim on any of the assets or Proprietary information, belonging to the Company and shall never initiate any action to claim a share in the same.
- B) CONFIDENTIALITY:** The CD will not use or disclose to any Third Party, any Proprietary Information provided to him by the Company for any other purpose except that specified in the Business Plan.
- C) INTELLECTUAL PROPERTY:** The CD will not copy, add to, alter, amend or deface the Trademark or Trade Name of the Company. The CD will also not use the said Trademark of the Company for any other purpose except to market the Package of the Company according to the Business Plan.
- D) INDEMNITY:** The CD shall indemnify and continue to hold the Company and its Directors, Employees and Agents indemnified against all claims made by any Third Party or Customer or CD prospected by him/her and any related damages and expenses including the legal expenses arising out of or connected to the conduct of CD (in connection with any false claims, promises and other assurances made by him which are not made by the Company in writing). The liability of the CD arising from this clause shall continue regardless of whether the action brought by such third party actually succeeds or not.
- E) DISCLAIMER:** Company hereby expressly disclaims any liability towards any harm, damage, prejudice or suffering to any CD or his/her beneficiary caused due to any negligence on the part of one or more doctors or auxiliary staff employed by the Diagnostic Centre / Hospitals. Although the Company shall endeavour to provide the best medical service to its CDs, it makes no warranties expressed or implied regarding the diagnostic services provided by the said Diagnostic Centre.
- F) ENTIRE AGREEMENT:** The Business Plan of the Company and the Statement Rules and Regulations as amended from time to time and any addendum as displayed on the notice board maintained in the marketing office of the Company and all such documents constitute the entire agreement of the parties regarding their business relationship. The Company expressly reserves the exclusive right to alter or amend these Rules and Regulations. Upon updation on the website or notification by display on the notice board maintained in the marketing office of the company such amendments are automatically incorporated as part of this Agreement between the Company and the Customer and the CD and are binding upon the parties.
- G) RENEWAL FACILITY:** During the validity of this agreement, 15% of the net incentive earned by the Customer Distributor in the fortnight (with the maximum of Rs. 2500 or the amount with which he/she renewed his/her Customer Distributorship previously, whichever is more) shall be deducted and kept aside. The amount so kept aside shall either be adjusted towards next year's Renewal or shall be refunded to the Customer Distributor if he/she decides not to renew his/her Customer Distributorship, provided the concerned Customer Distributor notifies the Company, in writing, at least 30 days before the date of renewal that he/she does not wish to renew his/her Customer Distributorship.
- H)** The Company will not be responsible in case communication / incentive is not received by the CD due to incomplete address given by him / her.
- I)** The signature in the application form will be taken as the CD's specimen signature.

PAYMENT

All payment on the purchase of the Product should be made in favour of 'Indus Health Plus (P) Ltd.' by /DD / Pay order payable at Pune only.

Cash payment can be tendered directly by you into our collection accounts opened in various cities for your convenience. The senior CD's in these cities will give you the name, branch and collection A/c numbers of these centres. In other cities where this facility is not available, payment will be accepted by Demand Draft (DD) only. The company will not take responsibility for any payment made otherwise and it shall be at your own risk.

REFUND

No refund will be given after 15 days from the day the payment is made to the company. However, in case a written request for refund reaches the company within 15 days along with the Sales Kit given at the time of enrolment, the entire amount paid (without Interest-subject to a deduction of Rs. 500/- as administrative charges) will be refunded by Cross A/c Payee Cheque only.

DECLARATION

I _____ son/daughter/wife of _____ hereby declare that every thing written in this form and in the Family Information Form (FIF) is completely true and no material has been concealed from the Company. I understand that if any information mentioned in the form or the FIF is discovered to be false or if any material information is found to be withheld by me, the Company shall be entitled to terminate the contract with me and withdraw the Facility with immediate effect. I have read and understood all the terms and conditions and will be bound by the same

Signature of CD/Customer _____