

Proposal Form No.:

ManipalCigna Health Insurance Company Limited
(Formerly known as CignaTTK Health Insurance Company Limited)
Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (E), Mumbai - 400063. IRDAI Registration No. 151.
Call (Toll Free): 1800-102-4462 Visit: www.manipalcigna.com
E-mail: customercare@manipalcigna.com CIN No.: U66000MH2012PLC227948



Photograph of Insured 1

Photograph of Insured 2

Photograph of Insured 3

Photograph of Insured 4

Photograph of Insured 5

Photograph of Insured 6

Photograph of Insured 7

Photograph of Insured 8

FOR OFFICE USE ONLY

Branch Name: Branch Code: Intermediary Name: Intermediary Code: Agent Code / Broker Code / CA Code Business Type: Urban / Social / Rural Ops Tags: Employee DMS Code: ManipalCigna Employee DMS Code Partner Vertical Name: Partner Business Vertical Code Partner Branch ID: Partner Branch Code Sub Intermediary Name: <<For POSP>> Sub Intermediary PAN: <<For POSP>> Other Details: <<For POSP>>

Ref. A Ref. B

MANIPALCIGNA ACCIDENT SHIELD PROPOSAL FORM

Ref. C

- 1 Please fill the form in BLOCK LETTERS. 2 All details marked with * are mandatory. 3 The Proposer must authenticate the cancellations/alterations in this form.

For Staff Rebate* please provide: Name of the organization: Name of the Employee: Employee ID:

* Applicable only if Proposer or any Insured person under the policy is employee of: ManipalCigna, Promoter group/Group entity of the Promoter group/ Promoter of the Promoter group/ Group entity/ Group entity of the Group entity of ManipalCigna. The issuance of this form by ManipalCigna Health Insurance Company Limited (the Company) does not amount to acceptance of proposal. The actual liability of the Company does not commence until this proposal has been accepted by the Company and premium realized.

I. PROPOSER DETAILS*:

Title* : Mr. Mrs. Ms. Gender* : Male Female Others Tick if Employer is the Payor: Date of Birth* : DD MM YYYY Marital Status* : Married Single Others Name*(as in bank account): F I R S T N A M E M I D D L E N A M E S U R N A M E Permanent Address*: (As per the KYC proof submitted): Landmark: City*: Town (District): State*: Pin Code*: Gram Panchayat: Correspondence Address*: If same as above, please tick here Landmark: City*: Town (District): State*: Pin Code*: Gram Panchayat: Email Address* : Address 1 Address 2 Telephone Number(s) : Mobile*: Residence (Optional): Office(Optional):

Would you like to subscribe to important alert on Whatsapp? Yes No

Policyholders have the option to access their Policy documents through DigiLocker with no additional charges.

To learn more about DigiLocker, please visit <https://www.manipalcigna.com/video/>

Would you prefer to receive all policy document digitally (via email/soft copy)?

Yes (I would like to receive policy document digitally). No (I prefer to receive policy document in hard copy).

Occupation* : Government Service Private Service Self Employed Others

Annual Income* : Up to ₹50,000 ₹5 to ₹10 Lacs ₹15 to ₹20 Lacs
₹50,000 to ₹5 Lacs ₹10 to ₹15 Lacs Above ₹20 Lacs

Educational Qualification* : Less than class X Class X Class XII Graduate Post Graduate Professional Degree

Customer Goods & Service Tax Identification Number (if any):

Residential status* : Indian NRI If NRI, Please mention country Others (Please specify)

PAN Card Number* :

Form 60* (only in case where PAN number is not available) Yes No

Identity Document Type : Aadhaar Card Driving License Passport Voter's ID card Others

VID Number (Please mention only last four digits of your Aadhaar^^ or VID):

CKYC number : EIA number:

PEP or relative of PEP:

Family Physician Details:

Name :

Contact number : Email id:

Address :

Do you wish to assign a Caregiver for your Policy/ies: Yes No If Yes, please provide:

Name* :

Mobile number* : Relationship with Proposer:

Age (in Years) : Email id:

Caregiver can be a close family member who would take care of the Insured Person in any kind of health care event, whether emergency or planned. The Caregiver might not be the SOS contact.

^^Please provide the details to enable us to serve you better.

II. NOMINEE DETAILS*:

Is the Nominee same as Caregiver (if provided above)? Yes No. If No, please provide Nominee details.

S. No.	Particulars	Nominee 1	Nominee 2	Nominee 3
1	Name			
2	Age			
3	Mobile No.			
4	Email ID			
5	Correspondence Address			
6	Permanent Address			
7	Relationship with Proposer			
8	Specify the percentage (%) of the claim amount payable to each nominee in the event of the policyholder's death. The total percentage of contribution across all the nominee must not exceed 100%			
9	Bank Details of Nominee Account No. IFSC/MICR Code Name of Bank Account Holder Name			
10	Appointee Details (Required only if nominee is a minor) Name Age ^f Mobile No. E-mail ID Relationship with Nominee			

As per recent regulatory mandate, nomination details are mandatory to be provided by the customers. Please provide your nominee details urgently by emailing us at customer@manipalcigna.com, contacting us on 1800-102-4462, or visit our nearest branch.

In the event of death of the Proposer, any payment due under the Policy shall become payable to the nominee, as per the 'Nomination' clause defined by the IRDAI and the receipt of the proceeds by such nominee would be sufficient discharge to the Company.

For all other persons covered under the Policy, the Proposer will be the nominee.

^fA Minor should not be declared as Appointee.

III. POLICY/PLAN DETAILS*:

Plan Type*:	Plan Name:	Tenure:
Individual <input type="checkbox"/>	Classic <input type="checkbox"/>	1 Year <input type="checkbox"/>
Floater <input type="checkbox"/>	Plus <input type="checkbox"/>	2 Year <input type="checkbox"/>
In case of Family Option - Sum Insured for Non earning spouse will be limited to 60% of the Proposer and for Dependents (Children/Parents/In-laws) will be limited to 30% of the Proposer.	Pro <input type="checkbox"/>	3 Year <input type="checkbox"/>

INSURED DETAILS*: (Sum Insured only for individual cover)

SR NO	1	2	3	4	5
Name (First*, Middle, Last*)					
Gender*					
DOB*					
Relationship with Proposer*					
ABHA Number^^					
Height* (Cms)					
Weight* (Kgs)					
Occupation/ Industry Type/ Nature of Job*					
City*					
Gainful Annual Income*					
Temporary Total Disablement					
Loss of employment SI (in ₹) - Options - 50k to 500k (in multiples of ₹ 10K) - The pay-out under Loss of Employment would be lowest of Loss of Employment Sum Insured or current salary totalling to 3 months - At each Renewal Insured can change the Sum Insured under this cover basis the current salary					
Loan shield SI (in ₹) - Options - 1Lac to 1 Cr (in multiples of ₹ 10K) - The pay-out under Loan shield would be lowest of Loan Shield Sum Insured or actual outstanding Loan Amount. - At each Renewal Insured can change the Sum Insured under this cover basis the current outstanding Loan Amount.					
EMI shield SI (in ₹) - Options - 50K to 500K (in multiples of ₹ 10K) - The pay-out under EMI Shield would be lowest of EMI Shield Sum Insured or 3 outstanding EMIs - At each Renewal Insured can change the Sum Insured basis the current outstanding EMI Amount.					
Child Welfare Benefit					
Sum Insured*					
Insured address if different from Proposer					
If PEP ^ (Y / N)					
C-KYC number					

^Politically exposed person

If PEP details are not provided, we will consider the same as "No".

^^Please provide ABHA number (Ayushman Bharat Health Account number) for all the proposed Insured Persons. In case the ABHA number is not available for any Insured Person, you may request to create an ABHA number by visiting the web link: <https://healthid.ndhm.gov.in/register>.

All insured Indian national and Indian residents? Yes No

If No, Please mention country _____

Note:

ManipalCigna Accident Shield: The minimum entry age under this policy is 18 years and maximum age at entry is 70 years. Dependent child/children shall be covered from the age of 5 years to 25 years.

1. ManipalCigna Accident Shield

Base cover includes Death, Permanent Total Disablement Permanent Partial Disablement, Funeral expenses, Repatriation of Mortal Remains as per opted plan.

OPTIONAL COVERS	
Classic & Plus	Pro
Burns benefit <input type="checkbox"/>	Burns benefit <input type="checkbox"/>
	Broken Bones Benefit <input type="checkbox"/>
Coma Benefit <input type="checkbox"/>	Coma Benefit <input type="checkbox"/>
Air Ambulance <input type="checkbox"/>	Air Ambulance <input type="checkbox"/>
Accidental Hospitalization <input type="checkbox"/> (This cover will be applicable for each insured members) ₹ 5 Lac <input type="checkbox"/> ₹ 10 Lac <input type="checkbox"/> ₹ 15 Lac <input type="checkbox"/> ₹ 20 Lac <input type="checkbox"/> ₹ 25 Lac <input type="checkbox"/> ₹ 50 Lac <input type="checkbox"/>	Accidental Hospitalization <input type="checkbox"/> (This cover will be applicable for each insured members) ₹ 5 Lac <input type="checkbox"/> ₹ 10 Lac <input type="checkbox"/> ₹ 15 Lac <input type="checkbox"/> ₹ 20 Lac <input type="checkbox"/> ₹ 25 Lac <input type="checkbox"/> ₹ 50 Lac <input type="checkbox"/>
	Adventure Sports Cover <input type="checkbox"/>
Medical Repatriation <input type="checkbox"/>	Medical Repatriation <input type="checkbox"/>

Note- 1) The benefits listed above are applicable to all insured members without any individual selection.

2) Member level optional covers are provided under insured section.

Applicable Discounts:

a. **Corporate discount**- Corporate discount- 5% of one-time discount for an employee who is working in any Public or Private Limited Companies (Submission of ID Card is mandatory)

Name of Company-

HR Email ID-

Employee ID-

Employee Email ID-

b. **Long Term policy discount** (Applicable only with Single premium payment mode)

- i. For Policy Period of 2 years - 7.5% on the total applicable premium
- ii. For Policy Period of 3 years - 10% on the total applicable premium

c. **Online Renewal Discount** of 3% discount on the renewal premium, if the renewal premium is received through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card)

d. **Worksite Marketing Discount** Worksite Code: Employee id:

(Applicable only once at the time of inception)

Note - Only one of the following discounts can be opted - Worksite discount / Staff discount / Corporate discount

Maximum Discount in any policy year cannot exceed 25%.

Premium payment mode: Monthly^ Quarterly Half yearly Yearly

^3 months premium to be paid in advance and instalment/renewal premium payment through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card)

Note: Please note that your Policy period will start from premium received date at our branch office in case of cash payments or/ as per instrument date when paying through Cheque/ demand draft/ pay order. In case of credit card/ debit card transactions, Policy period will start from date of debit of requisite premium from the Proposer's card/ bank account.

IV. MEDICAL AND LIFESTYLE INFORMATION*:

ManipalCigna Accident Shield		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q1	Does any proposed to be insured suffer from any terminal illness, seizure disorders or any disease/deformity affecting or restricting mobility, sight, hearing or speech?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Q2	Does any proposed to be insured's occupation or nature of duties require them to be a part of armed forces, expose them to hazardous substances/chemicals** or hazardous activities**	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

**Hazardous substance/ chemicals: Substances, chemicals, mixtures which pose a significant risk to health and safety (Inflammable or combustibles, carcinogens, Allergens, Irritants, asphyxiants, toxic gases, pesticides, poisonous substances, compressed gases, explosives etc)

**Hazardous activities: Working underground, Flight cabin crew, crew on river/sea faring vessels, manual work at heights (line layers, window cleaners etc), Working with high voltage, working with high heat or high pressure gases, Manual labourers/workers, driving commercial heavy vehicles.

V. ADDITIONAL MEDICAL INFORMATION:

If answers to above questions are 'Yes', please provide further details below. Please attach extra sheets if required.

Sr.No.	Additional Medical Information	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
a.	Exact Diagnosis								
b.	Year of diagnosis								
c.	Treatment taken: Surgical/ Medical / No treatment / Defaulter (left treatment on own)								
d.	Current status - Cured/ On treatment / Pending surgery or treatment								
e.	Complications/ Recurrences - Yes/No								
f.	Last consultation date - "Month/Year" to be provided								
g.	Histopathology Examination Report (only for surgical) - No abnormality, Malignancy/ borderline malignancy/ Tuberculosis								

Signature of Proposer *:

(A policyholder or prospect, who is a person with disability, may duly authorize a representative to give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)

VI. PREVIOUS/ CURRENT INSURANCE DETAILS:

Please fill the following details with respect to health insurance policies(s) currently or held with the Company or any other insurance company (Individual or Group)?

Insured	Policy No.	Type of Policy e.g. Mediclaim, PA, CI, Hospital Cash	Insurer Name	From Date	To Date	Sum Insured	Claim Details			Cumulative Bonus Earned		Has any proposal for life, health, hospital daily cash or critical illness insurance on the life of the applicant ever been declined, postponed, loaded or been made subject to any special conditions such as exclusions by any insurance company?
							Claim Number	Claimed Amount	Ailment	%	Amount	
Insured 1												
Insured 2												
Insured 3												
Insured 4												
Insured 5												
Insured 6												
Insured 7												
Insured 8												

For active policies, please attach policy copies.

Insured wise information required with all the above information in Previous/Current Insurance Details.

VII. PAYMENT DETAILS*:

Premium Paid by :	<First> _____ <Middle> _____ <Last> _____	Relationship to Proposer :	_____
Premium Amount :	_____ in Words _____		
Signature :	_____		
Payment Option:	Cheque <input type="checkbox"/>	Demand Draft <input type="checkbox"/>	Pay Order <input type="checkbox"/>
	Credit Card <input type="checkbox"/>	Debit Card <input type="checkbox"/>	Cash <input type="checkbox"/>
For Cheque / DD / Credit Card/ Debit Card/ PO/ Others (Please specify) _____ (Payable in favour of "ManipalCigna Health Insurance Company Limited" – Proposal form No. _____)			
Instrument / Transaction Number :	_____	Instrument/Transaction Date:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Instrument /Transaction Amount :	_____		
Bank Name :	_____		
Payment to be collected only from Proposers Card/Bank Account			

VIII. BANK ACCOUNT DETAILS*:

Mandatory details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account. Please select any one of the below options as applicable.

Bank details as per premium cheque to be used for electronic fund transfer/refund.
 Bank account details as mentioned on the cheque being submitted along with the Proposal Form towards premium payment for insurance Policy should be used by the Company for electronic fund transfer as mode of payment.
 Please fill the below table if the premium payment cheque does not have all the details required for electronic fund transfer.

Particulars of Bank Account*:

Account Number:	<input type="text"/>
IFSC / MICR Code:	<input type="text"/>
Name of the Bank:	<input type="text"/>
Account Holder Name:	<input type="text"/>

I agree and undertake to intimate in writing to ManipalCigna Health Insurance Co. Ltd about any change in bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

DISCLAIMER: ManipalCigna shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation- failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder.

Aforesaid NEFT transaction shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. ManipalCigna shall be indemnified against any loss/damage/claims caused to ManipalCigna in carrying out your aforesaid NEFT instructions.

Instructions:

- It is important for these electronic payment systems that the Policy Holder's name in the Policy must exactly match with the name in the Bank Account records/details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required.
- The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFS Code, which is applicable for NEFT only. (a number allotted to each participating banks branch) of the branch where the funds need to be transferred.
- Cancelled cheque should be attached along with the NEFT format.
- In case cancelled blank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required.
- NEFT Form needs to be complete in all respect.

Date:

Signature of Proposer *: _____
(A policyholder or prospect, who is a person with disability, may duly authorize a representative to give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)



