Title*	: Mr. Mrs. M	s. (Gender* : Ma	le Female	Others	Tick if
Date of Birth*	: DD MM YY	Y Y 1	Marital Status* : Mai	rried Single	Others	Employer is the Payor:
Name*(as in bank accou	nt): FIRSTN	A M E*	M I D D L	ENAME	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 h	ere					
	Landmark:					
	City* :			Town (District):		
	State*:				Pin Code*:	
	Gram Panchayat:					
Email Address*	: Address 1			Address 2		
Telephone Number(s)	: Mobile*:			Residence (Optional):		
	Office(Optional):					

	you like to subscribe to important alert on Whatsapp?	Yes No		
Policyh-	olders have the option to access their Policy docume	nts through DigiLocker with no addition	nal charges.	
To learr	n more about DigiLocker, please visit https://www.mar	nipalcigna.com/video/		
Would y	you prefer to receive all policy document digitally (via	email/soft copy)?		
Υe	es (I would like to receive policy document digitally).	No (I prefer to receive policy docu	ıment in hard copy).	
Occupa	ation* : Government Service Priv	ate Service Self Employed	Others	
Annual	Income* : Up to ₹50,000 ₹5	o₹10 Lacs ₹15 to ₹20 Lacs		
		to ₹15 Lacs Above ₹20 Lacs		
Educati		ss X Class XII Gradu		rofessional Degree
	ner Goods & Service Tax Identification Number (if any		ato Tool Gladdato1	Toroccional Bogree
	ntial status* : Indian NRI If NRI, Please		Others (Please specify)	
	ard Number* :			
	0* (only in case where PAN number is not available)	Yes No		
			ow's ID sound Otherus	
,	Driving L	icense Passport Vote	er's ID card Others	
	ar number^^/ (VID number) :			
	number :	EIA number:		
PEP or	relative of PEP:			
-	Physician Details:	ME MIDDLE	N A M E SUR	NAME
Name			N A W E S O K	N A W E
	t number :	Email id:		
Address	s :			
Do you	wish to assign a Caregiver for your Policy/ies: Yes	No If Yes, please provide	:	
Name*	FIRSTNA		N A M E S U R	N A M E*
Mobile	number* :		nship with Proposer:	
Age (in	Years) :	Email id	l:	
Caregive	er can be a close family member who would take care of the Insure	l Person in any kind of health care event, wheth	ner emergency or planned. The Caregiver mig	ht not be the SOS contact.
^Please p	provide the details to enable us to serve you better.			
	MINEE DETAILS*:			
S. No.	ninee same as Caregiver (if provided above)? Yes No. If No. Particulars	please provide Nominee details. Nominee 1	Nominee 2	Nominee 3
1	Name	TVOITIII OO T	Trominos 2	Trominos s
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 payab			
	to each nominee in the event of the policyholder's dea The total percentage of contribution across all the nominee must not exceed 100%	h.		
9	to each nominee in the event of the policyholder's dea The total percentage of contribution across all the	h.		
9	to each nominee in the event of the policyholder's dea The total percentage of contribution across all the nominee must not exceed 100% Bank Details of Nominee Account No. IFSC/MICR Code Name of Bank			
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As per reconn 1800-10 in the ever would be s	to each nominee in the event of the policyholder's dea The total percentage of contribution across all the nominee must not exceed 100% Bank Details of Nominee Account No. IFSC/MICR Code Name of Bank Account Holder Name Appointee Details (Required only if nominee is a minor Name Age" Mobile No. E-mail ID Relationship with Nominee pent regulatory mandate, nomination details are mandatory to be pro- 102-4462, or visit our nearest branch. Int of death of the Proposer, any payment due under the Policy shall sufficient discharge to the Company. For all other persons covered ur hould not be declared as Appointee. DLICY/PLAN DETAILS*:	ided by the customers. Please provide your nom	mination' clause defined by the IRDAI and the	

Sr No.	Name (First*,Middle, Last*)	Gender* (M/F/O)	DOB*	Relationship with Proposer*	ABHA Number ^{^^}	Height* (Cms)	Weight* (Kgs)	Occupation/ Industry Type/ Nature of Job*	-	Gainful Annual Income*	Sum Insured*	Insured Address If Different From Proposer	If PEP/ Relatives of PEP^ (Y/N)	C-KYC number
1														
2														
3														
4														
5														
6														
7														
8														
All in	P details are not provided, we vilease provide ABHA number (Anumber by visiting the web lines are detailed in the second in the	Ayushman Bhank: https://healt	arat Health A hid.ndhm.g	Account number) fo ov.in/register	or all the propos	ed Insured	Persons. In	case the ABHA nu	ımber is r	not available	for any Insu	red Person, yo	u may reques	t to create a
- Ma - Th	e. anipalCigna Critical Illr anipalCigna Lifestyle F ie maximum age at en nipalCigna Lifestyle F	Protection – try is 80 ye	Acciden	nt Care: The m	ninimum ent	try age u ren age	inder this is 25 yea	policy is 5 ye		_			ults.	
Pla	an Name*:		Plan T	ype*:					Option	nal Cover	s			
Pla	an A - Basic		Individ	ual					•	rary Total		ment		
Pla	an B - Enhanced		Family						`		_	member)		
Pla	an C - Comprehensive	•	will be li	of Family Opt mited to 60% ents will be lir	of the Prop	oser and	for	e	Coma	Benefit Benefit n: Critical		Broken Bon	es Benefit	
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a. b. c. d.	pplicable Discounts: Family Discount of 10 Long Term policy disco Direct Policy Discoul Worksite Marketi	count of 7.5 unt will not b nt of 10% if t	6% and 10 e applica his Policy	0% on selecting ble in case of ir is bought from ite Code:	a 2 and 3 ye stallment pre	ars policy emium po	respectiv blicies. nediary.	oyee id:	Ye	arly		Single		

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

^2 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*:

Fo	r Lifestyle Protection – Accident Care	Insured_1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q1	Has any of the applicants suffered or currently suffering from seizure disorder or any physical or mental defects/ impairment/ infirmity/ deformity or any condition that may effect mobility/ sight/ hearing/speech?	YES NO	YES NO	YES NO	YES	YES	YES	YES	YES NO
Q2	Does the applicant's occupation require him/her to engage in manual labour or hazardous activities or handling hazardous material or working at heights, as cabin crew, in sea/river faring vessels, with high voltage, or be a part of armed forces?	YES NO	YES	YES NO	YES	YES	YES	YES	YES NO
На	bits and Lifestyle questions	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q3	Does any of the insured/s chew tobacco/ smoke/ consume alcohol? Please tick the relevant box(es) below	YES	YES NO	YES NO	YES	YES NO	YES	YES	YES
A	Smoke	YES							
1	Since how long does the applicant smoke								
а	<=20 years								
b	>20 years								
В	Tobacco	YES NO							
1	How many Pan masala / gutka packets does the applicant has in a day								
а	1-3 packets/day								
b	4-6 packets/day								
С	>6 packets/day								
С	Alcohol	YES NO							
1	How frequently does the applicant consume alcohol								
а	1-3 days/ week								
b	3-6 days/week								
С	Daily								
Fo	r Critical Illness Add On Cover	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q4	Has any of the applicant ever been diagnosed with or suspected to have Cancer or Rheumatoid Arthritis or Ulcerative Colitis or Crohn's disease or Chronic Liver Disease, Hepatitis B, Cirrhosis or Chronic Kidney Disease or Kidney failure or Epilepsy or Fits or Stroke or Paralysis or Parkinsonism or Alzheimer's or Multiple sclerosis or Brain Tumor or Cerebral Palsy or Heart Failure or Heart Attack or Angina or Coronary Artery Disease or Ischemic Heart Disease or Chronic Bronchitis or Intestitial Lung Diseases or Pneumoconiosis or Emphysema.	YES NO							
Q5	Has any member ever suffered or currently suffering from or under treatment (operated, hospitalised, investigated) or been under medication for more than a week for any medical condition.	YES NO	YES	YES	YES NO	YES	YES NO	YES	YES NO
i	Diabetes Mellitus	YES NO	YES	YES NO	YES NO	YES NO	YES NO	YES	YES NO
ii	Hypertension	YES NO	YES NO	YES NO	YES	YES NO	YES NO	YES NO	YES NO
iii	High Cholesterol	YES							
iv	Thyroid disorders	YES	YES NO						
v	Heart and Lung disorders	YES NO	YES NO	YES	YES	YES	YES	YES NO	YES NO
vi	Digestive system disorders (Stomach and related organs)	YES	YES NO						
vii	Brain, nerve and Psychiatric (Mental) disorders	YES NO	YES	YES	YES NO	YES NO	YES	YES NO	YES NO
viii	Other Endocrine (Hormonal) disorders	YES NO	YES	YES	YES	YES	YES	YES	YES NO
ix	Bone, joints and muscle disorders	YES NO	YES NO	YES	YES	YES NO	YES	YES NO	YES NO
х	Ear, nose, eye and throat disorders	YES NO							
xi	Genito-urinary and Gynaecological disorders	YES							
xii	Blood and related disorders	YES							

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xiii	Skin disorders	YES NO							
xiv	Any other condition / illness / disorder / surgery	YES NO							
Q6	Has any of the applicants recommended to undergo or has undergone any pathologic or radiologic tests for any illness other than the ones listed above and routine or annual health check-up?	YES NO							
Q7	Is any applicant currently not in good health and undergoing any investigation or treatment or medication for any illness or medical condition (Physical/ Mental/ Sleep disorders)?	YES NO							
Q8	Have any first degree relatives (i.e. parents, brothers, sisters or children) of any of the applicants (who are not themselves applicants for this insurance policy) had cancer, motor neuron disease or any other hereditary disorders	YES NO	YES	YES NO	YES NO	YES NO	YES	YES NO	YES NO

V. ADDITIONAL MEDICAL INFORMATION:

If answers to Q5 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:

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 prophealth, hospital critical illness ir life of the applideclined, postor been made special conditions by comp	I daily cash or a surance on the cant ever been poned, loaded subject to any tions such as any insurance			
							Claim Number	Claimed Amount	Ailment	%	Amount	nt (Y – Yes / N – No)				
Insured 1												YES	NO			
Insured 2												YES	NO			
Insured 3												YES	NO			
nsured 4												YES	NO			
nsured 5												YES	NO			
nsured 6											YES	NO				
nsured 7												YES	NO			
nsured 8												YES	NO			

For active policies, please attach policy copies.

ManipalCigna Lifestyle Protection - Accident Care | UIN: MCIPAIP21123V022021 | URN: 2020/LPAC/V2.03/OFF | October 2024

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IX. DECLARATION & AUTHORISATION*: I/We 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/We am/are authorised to propose on behalf of these other persons. 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable. I/We further declare that I/We 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. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Government and/or Regulatory authority, including seeking and/or sharing of my medical data through ABHA. I hereby consent to and authorize ManipalCigna Health Insurance Company Limited ("Company") and its representatives to collect, use, share and disclose information provided by me, as per the privacy policy of the Company. Company or its representatives are also hereby authorised to contact me (including overriding my registry on NCPR/NDNC and/or under any extant TRAI regulations) and / or notify about the services being rendered by the Company. Further, I hereby provide my consent and authorize Company and its representatives to collect the premium upfront at proposal stage. I hereby further declare that I am also aware of the recent regulatory changes (details available at https://irdai.gov.in/web/guest/document-detail?documentId=5625747), wherein Insurer has been asked to collect premium after acceptance of proposal, however it would be difficult for me to subsequently submit premium at later stage to the insurer and hence I hereby request and authorize Insurer to accept my premium along with this proposal to avoid any inconvenience to me, at my sole cost and consequences. I hereby agree to the Terms and Conditions of the policy/ies. 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) Place: X. VERNACULAR DECLARATION: I hereby declare that, I have fully explained the contents of the proposal form and terms and conditions of the Policy to the Proposer in the language understood to him/her and that the Proposer has affixed the thumb impression above after fully understanding the contents thereof. 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) XI. ADVISOR / INTERMEDIARY DECLARATION*: In my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein that will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I further confirm that I have explained the product features, terms and conditions to the prospect and the product opted is suitable to the needs of the customer. I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company. License No. / ID (Advisor/Corporate Agent/Broker/Relationship Officer): Signature of Agent: Place: Section 41 of Insurance Act 1938 (Prohibition of rebates): 1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the 2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees. **ACKNOWLEDGEMENT:** (Tear Off)

Note: Neither the submission of a completed proposal for insurance or any payment for any Policy sought oblige the Company to agree to issue a Policy, which decision is and always shall be in the Company's sole and absolute discretion.

If ManipalCigna Health Insurance Company Limited accepts a proposal for insurance, it shall be subject to the board approved underwriting policy of the Company and the Policy terms and conditions of this product and the Company shall have no liability to make any payment if premium is not received by ManipalCigna Health Insurance Company Limited in full and in time, or is not realised.

Should you choose to pay premium by Cash, you are advised to do so only at the nearest ManipalCigna branch or its authorised collection points. Handing over cash to any Advisor/Employee is solely at your own risk and the Company shall in no way be held responsible for any loss in this regard.