

Plan Type*: Individual Floater Portability: Yes No (If yes portability form to be completed and attached) Migration: Yes No (If yes migration form to be completed and attached)

Sum Insured (INR in Lacs)
 ₹50,000 ₹ 1Lac ₹ 1.5 Lacs ₹2Lacs ₹ 2.5 Lacs ₹ 3Lacs ₹ 3.5Lacs ₹4Lacs ₹ 4.5Lacs ₹ 5Lacs
 ₹ 5.5Lacs ₹ 6Lacs ₹ 6.5 Lacs ₹7Lacs ₹7.5 Lacs ₹8Lacs ₹8.5Lacs ₹9Lacs ₹9.5Lacs ₹ 10Lacs

Applicable Discounts:
a. Family Discount 15% discount on the premium is applicable for covering 2 or more members under a Policy (Applicable only with cover on individual basis)
b. Worksite Marketing Discount Worksite Code: Employee id:
c. Online Renewal Discount (Discount of 3% on the premium from next renewal, if the premium is received through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card))
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)

IV. MEDICAL AND LIFESTYLE INFORMATION*:

Medical questions		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1.	Has any of the applicants 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 Intestinal Lung Diseases or Pneumoconiosis or Emphysema.	<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
2.	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.	<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
a.	Diabetes Mellitus	<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
b.	Hypertension	<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
c.	High Cholesterol	<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
d.	Thyroid disorders (Goitre, Hyperthyroidism, Hypothyroidism, Thyroiditis, any other)	<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
e.	Heart and Lung disorders (Asthma, Tuberculosis, Upper Respiratory Tract Infection, Lower Respiratory Tract Infection, Varicose veins, Deep vein thrombosis, Syncope, Hypotension Low Blood Pressure, Varicocele, any other heart and lung condition)	<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
f.	Digestive system disorders (Peptic ulcer, Appendicitis, Cholecystitis/Cholelithiasis (Gall Bladder stones), Piles, Anal Fissure, Anal Fistula, Pancreatitis, Umbilical Hernia, Inguinal Hernia, Irritable bowel syndrome, Fatty liver, any other)	<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
g.	Brain, nerve and Psychiatric (Mental) disorders (Recurring or severe headaches / Migraine, Febrile Convulsions, Vertigo, Mental Retardation, Anxiety, Depression, Psychosis, Any other Psychological disorder, Dementia (Memory loss), Attention deficit Disorder, any other)	<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
h.	Other Endocrine (Hormonal) disorders (Parathyroid gland disorders, Adrenal Disorder, Pituitary Disorders, any other)	<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
i.	Bone, joints and muscle disorders (Gout / Hyperuricemia, steoarthritis, Shoulder Dislocation, Spondylitis / Spondylosis, Osteoporosis, Prolapse of Inter-vertebral disc (disc prolapse), Total Knee Replacement, Total Hip Replacement, any other)	<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
j.	Ear, nose, eye and throat disorders (Otitis-media (middle ear infection), Hearing loss, Nasal Polyp, Sinusitis, Deviated Nasal Septum, Tonsillitis, Pharyngitis, Cataract, Glaucoma, any other)	<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
k.	Genito-urinary and Gynaecological disorders (Kidney / bladder stones, Recurrent Urinary tract infection, Stricture Urethra, Cystitis/ Infection of urinary bladder, Benign Hypertrophy of Prostate, Hydrocele, Torsion of testes, Phimosis, Breast lump, Ovarian cyst, Endometriosis, Fibroid, irregular or excessive bleeding, Bartholin's abscess / cyst, any other)	<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
l.	Blood and related disorders (Anaemia, Thalassemia, Sexually transmitted diseases, HIV / AIDS (Acquired Immuno-deficiency syndrome), any other)	<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
m.	Skin disorders (Psoriasis, Eczema, Dermatitis, Urticaria, Vitiligo, Cyst/ lump/ growth / polyp / tumour, any other)	<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
n.	Any other condition / illness / disorder / surgery	<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
3.	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?	<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
4.	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)?	<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

HABITS AND LIFESTYLE QUESTIONS		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1.	To be answered by applicants who chew tobacco / smoke / consume alcohol. Please tick the relevant box(es) below	<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
A.	Smoke	<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
1.	Since how long does the applicant smoke					
a.	<=20 years (<input checked="" type="checkbox"/> Tick if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	>20 years (<input checked="" type="checkbox"/> Tick if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	Tobacco	<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
1.	How many Pan masala / gutka packets does the applicant has in a day					
a.	1-3 packets/day (<input checked="" type="checkbox"/> Tick if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	4-6 packets/day (<input checked="" type="checkbox"/> Tick if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	>6 packets/day (<input checked="" type="checkbox"/> Tick if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	Alcohol	<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
1.	How frequently does the applicant consume alcohol					
a.	1-3 days/ week (<input checked="" type="checkbox"/> Tick if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	3-6 days / week (<input checked="" type="checkbox"/> Tick if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Daily (<input checked="" type="checkbox"/> Tick if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

V. ADDITIONAL MEDICAL INFORMATION:

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

Sr. No.	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Name of Insured					
Name of illness/injury suffering from or suffered in the past					
Date of first diagnosis (Month & Year)					
Name of Medication/Treatment received /receiving					
Whether fully cured					

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 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. Medclaim, PA, CI, Hospital Cash	Insurer Name	From Date	To Date	Sum Insured	Claim Details			Cumulative Bonus Earned	
							Claim Number	Claimed Amount	Ailment	%	Amount
Insured 1											
Insured 2											
Insured 3											
Insured 4											
Insured 5											

VII. Current Insurance Details

In the unfortunate event of claim, the below information will facilitate Us, in case you have chosen Us as a Primary insurer to coordinate with other insurers to ensure the hassle free settlement of your claim as per the applicable policy terms and conditions.

Please fill the following details with respect to health indemnity insurance policies(s) currently with any other insurance company?

Insured	Policy No	Insurer Name	From Date	To Date	Sum Insured	Cumulative Bonus Earned	
						%	Amount
Insured 1							
Insured 2							
Insured 3							
Insured 4							
Insured 5							

For active policies, please attach policy copies.

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

VIII. PAYMENT DETAILS*:

Premium Paid by:	First	Middle	Last	Relationship to Proposer: _____
Premium Amount:	_____ in Words _____			
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: _____
Instrument /Transaction Amount:	_____			
Bank Name:	_____			

Payment to be collected only from Proposers Card/Bank Account

IX. 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:	_____
IFSC / MICR Code:	_____
Name of the Bank:	_____
Account Holder Name:	_____

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:

D	D	M	M	Y	Y	Y	Y
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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)



