ManipalCigna	Health	Insurance	Company	Limited
mamparorgila	Houitii	mount	Company	LIIIIICG

Proposal Form No.:

(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

m Manipal © Cigna

		E	E-ma	àil: c	usto	ome	rcare	e@ı	man	ipal	_								H20	12P	LC2	279	948										
Branch Name*:												FO	R O	FFI	CE	USE	01		and	h C	ode:												
Intermediary Nar	me:																	Int	ern	nedia	ary (Cod	e*: /	\ger	nt C	ode	/ Bro	oke	r Co	de / (CA (Code)
Business Type:	Urban /S	ocial /	Rui	ral																													
Ops Tags:	Employee Sub Inter					alCi	gna E	Emp	oyee	e DM	S C	ode					Nan		artn	ner B	usine	ess \	/ertic	al C	ode		tner er D			D: Pa	artne	r Bra	nch Cod
Ref. A	Oub Inter	modiai	y ive	arrio.									Oub	, 11100	, iiii	Julia	iy i 7									— \	CI D	Ctai	10.				Ref. C
Ref. B				AF	₹0	G'	ΥA	S	A٨	IJ	ĒΕ	V	۸N	l P	O	LI	CY	, N	lΑ	NI	PA	L	CIC	ί	Α								
											(F	PRO	OPO)S	AL I	FΟ	RM)															
	Please fill t BLOCK LE							2	All	deta	ails ı	mark	ced v	with	* are	e ma	ndat	ory.				3								cate th			>
For Staff Rebate [#]	please p	rovide	: Na	ıme d	of th	e or	gan	izat	ion:																								
Name of the Emp "(Applicable only if Propose	•	d person i	under	the pol	icv is e	employ	ee of:	Manir	alCigr	na. Pro	mote	r arou	p/Grou	ıp enti	itv of ti	he Pro	omoter	aroup	/ Pron	noter o	f the F	romot	ter aro	up/ Gr			loye Froup e			Group e	ntity of	Manip	alCigna).
The issuance of this fountil this proposal has Proposer De	rm by Manip been accep	palCigna	а Неа	alth In	nsurar	nce (Comp	any	Limit	ed (th																							
Title*	:		Mr.		М	rs.		N	ls.		(3en	der*	:		N	Лale			Fe	mal	е		Oth	ers		7	Tic	ck if	Emp	oloye	ər	
Date of Birth*	:		D	D	M	M	Υ	Υ	Y	Υ	Ν	Лari	tal S	Statu	ıs*:	N	Лarri	ed		Sir	ngle			Oth	ers		ĺ	is	the f	Payo	r:		
Name*	:				F	T	R	S	T*						M	I	D	D	L	Е			T			L	Α	S	T*		Ī	$\overline{}$	
Permanent Addre	ess* :				T		T									T	T						T			T			T		寸	寸	
			Lan	ndma	ırk:					Ì																	Ī		Ī		T	T	
			City	/*:	Ī												To	own	(Di	stric	t):								Ī		Ī	T	
			Sta	te*:	Ī																				Р	in C	ode'	k:			T	T	
			Gra	am Pa	ancl	haya	at:	Τ	T	T																							
Correspondence		:																															
If same as above, please	tick here		Lan	ndma	ark.																						П		T	П	寸	寸	
			City				T										Т.	าพก	(Di	stric	t).		Ħ			Ħ	Т		T	П	寸	寸	
			Sta		Ī		$\overline{}$												(5).		.,.				Р	in C	ode'	*.		П	\exists	\pm	
				am Pa	ancl	hava	at.	\exists	$\overline{}$		\top														, .		ouo	•					
Email Address*				dress	Г	ilaye]	Add	ress	: 2.											
Telephone Numb	er(s) :			bile*:	L											Π			1	side			otion	al):		Τ			Т		$\overline{}$	$\overline{}$	
Would you like to						t on	Wh	ats/	`aa	? _	Y	es		No)]			(-1		,-									
Policyholders har To learn more ab Would you prefer Yes (I would	out DigiLor to receiv	ocker, re all p	plea olicy polic	ase w y doo cy do	visit I cum ocum	http ent nent	s://w digit t digi	/ww ally	.ma (via	nipa em	ilcig ail/s	na.d	copy	/vide y)?	eo/					nal men				oy).									
				ice(C												L	<u> </u>								7					г	_		
Occupation	:		Gον	vernr	nen	t Se	rvice	e			Pr	ivat	e Se							Self	Em	ploy	/ed					Ot	thers	, 	ᆜ		
Annual Income	:		up t	to ₹5	50,00	00								₹ 5	5 to	₹10) Lad	S							₹	15	to ₹	20	Lacs	; [닉		
			₹ 50	0,000) to =	₹ 5	Lacs	S						₹ 1	10 to	ე ₹ 1	5 La	acs			1				Α	bov	e₹2	20 L	.acs		ᆗ		
Educational Qua	lification :			s tha		lass	X								ass.		4]						XII	امد	D	[[닉		
Customer Cond	. 0 Camila			aduat		. NI.	م ما ممد	/:4		۸. [PO	SIG	Frac	luate	;							P	roie	ssio	лаі	Deg	ree			
Customer Goods		етах		Г	JUON	1 INU		È	一 [*]	, [Diag			4:))))	- /D			:6	[
Residential Statu			Indi	an	井		NRI	<u> </u>		II IN	κi, i	Piea	ise i	пеп	ILIOIT	CO	untry						Jule	I (P	ieas	se sp	oecif	у) [
PAN Card Numb		oro D/	\ NI _		or it	2 20	t 0)//	اماند	olo):		Vo			No																			
Form 60* (only in					eris	7			,		Ye	,	Door	No	+		١./	otor!	'o IF	o ca	-d [the							
Identity Documer	it type . F	Aauna	ar C	aru	<u></u>] L	rivir	ıg L	icen	ise		'	Pas	-									B. /I	B /I		unei	S		1				
VID Number (Please mention only last four digits of you Aadhaar or VID)														DO	cun	nen	t Exp				D	D	M	M	Y	Y	Υ	Y]				
CKYC number	: :																	LΙΑ	nu	mbe	r:												
PEP or relative o	ıPEP :																																

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

7
0
5
$\tilde{}$
.,
'n
ď
tobe
Ċ
÷
_
C
_
_
111
Ħ
Щ
\sim
\approx
S
÷
2
`
<
Ù.
1/S
◁
_
$\overline{}$
$^{\circ}$
IRN: 202
٠,
÷
2
n
≌
_
_
_
$\overline{}$
2
6
_
$\overline{}$
$\overline{}$
C
>
-
2
$\overline{}$
2
0
S
5
<u>Б</u>
2 =
<u>`</u>
ACIHI IP2
=
2
2
2
IN MOIT IDS
2
IIN. MCI
IIN. MCII
ManipalCiona I IIN MCI
ManipalCiona I IIN MCI
ManipalCiona I IIN MCI
Licy ManipalCiona IIIN MCI
Licy ManipalCiona IIIN MCI
Licy ManipalCiona IIIN MCI
Licy ManipalCiona IIIN MCI
Licy ManipalCiona IIIN MCI
ani Policy ManipalCiona I IIN: MCII
ani Policy ManipalCiona I IIN: MCII
vani Policy ManipalCiona I IIN: MCII
evani Policy ManinalCiona I IIN: MCII
Policy ManipalCiona I IIN MCII
ipeyani Policy ManinalCiona I IIN MCII
ipeyani Policy ManinalCiona I IIN MCII
ipeyani Policy ManinalCiona I IIN MCII
ipeyani Policy ManinalCiona I IIN MCII
ipeyani Policy ManinalCiona I IIN MCII
ipeyani Policy ManinalCiona I IIN MCII
ipeyani Policy ManinalCiona I IIN: MCII
ipeyani Policy ManinalCiona I IIN: MCII
Sanjeevani Policy ManipalCigna I I IIN: MCII
Sanjeevani Policy ManipalCigna I I IIN: MCII
Sanjeevani Policy ManipalCigna I I IIN: MCII
ipeyani Policy ManinalCiona I IIN: MCII
Sanjeevani Policy ManipalCigna I I IIN: MCII

Family	Physician Details:									
Name	: F R S T	N A M E		M I D D L	. E I	N A M E	S U R	N A M	E	
Contac	et number :			Email id	l:					
Addres	ss :									
Do you	ı wish to assign a Caregiver for your Policy	/ies: Yes	No	If Yes, pleas	e provi	de:				
Name*	FIRST	N A M E	*	M I D D L	. E 1	N A M E		N A M	E*	
Mobile	number* :			Relation	nship w	ith Proposer:				
Age (in	Years) :			Email id	l:					
	er can be a close family member who would take care	of the Insured P	erson in any	kind of health care e	event, wh	ether emergency or plann	ed. The Caregiv	ver might not b	ne the SOS contact.	
	provide the details to enable us to serve you better. MINEE DETAILS*:									
Is the Nor	ninee same as Caregiver (if provided above)? Yes	No. If No, ple	ase provide l	Nominee details.			_	<u> </u>		
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 to each nominee in the event of the policyho. The total percentage of contribution across a nominee must not exceed 100%	lder's death.								
9	Bank Details of Nominee Account No. IFSC/MICR Code Name of Bank Account Holder Name									
10	Appointee Details (Required only if nominee Name Age [#] Mobile No. E-mail ID Relationship with Nominee	is a minor)								
contacting	Leent regulatory mandate, nomination details are man g us on 1800-102-4462, or visit our nearest branch. Sent of death of the Proposer, any payment due under the control of the proposer.									
	by such nominee would be sufficient discharge to the C							idea i ine to tin	no dria tre receipt of th	
III. PO	LICY/PLAN DETAILS*:									
	e*: 1 Year	(Must be on o	Policy Period: From DDMMYYYYYAT : Hrs							
INSUF	RED DETAILS*: (Sum Insured and I	Deductible of	only for i	ndividual cove	er)		1			
SR NO)	1		2		3		4	5	
Name (First*.	Middle, Last*)									
Gender	·									
DOB*										
	nship with Proposer*									
	Number^^^									
Height*										
Weight										
<u> </u>	ation/ Industry Type/ Nature of Job*									
City*	anorii industry rype/ trature of Job									
_	sured* (only for individual cover)									
	I address if different from Proposer									
	· · · · · · · · · · · · · · · · · · ·									
If PEP										
C-KYC	number									
If PEP de ^^^Please to create	lly exposed person, etails are not provided, we will consider the same as "l e provide ABHA number (Ayushman Bharat Health Ac an ABHA number by visiting the web link: https://heal	count number) fo thid.ndhm.gov.in/	register.	posed Insured Person	ns. In cas	se the ABHA number is no	t available for a	ny Insured Pe	rson, you may request	
	insured Indian National and Indian Residents' ease mention country	Yes	No							

NO	
NO	
NO	
NO	
NO	24
NO	ber 200
NO	2/OFF Octo
NO	21/AS/V2.02
NO	920 URN: 20
NO	56V011
NO	CIHLIP201
NO	na UIN: M
NO	, ManipalCign
NO	ni Policy,
NO	njeevar
NO	a Sar
NO	Arogya
NO	

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 ₹3.5	5Lacs ₹4Lacs	₹ 4.5Lacs ₹ 5Lacs					
₹ 5.5Lacs ₹ 6Lacs ₹ 6.5 Lacs	₹7Lacs ₹7.5 Lacs	₹8Lacs ₹8.5	iLacs	₹9.5Lacs ₹10Lacs					
Applicable Discounts:									
a. Family Discount 15% discount on the prem	nium is applicable for covering 2 or r	more members under a Po	olicy (Applicable only	with cover on individual basis)					
b. Worksite Marketing Discount Worksite Code: Employee id:									
c. Online Renewal Discount (Discount of	of 3% on the premium from next re	newal, if the premium is i	received through NA	CH or standing instruction					
(where payment is made either by dire	ct debit of bank account or credit of	ard))							
Premium payment mode: Monthly	^ Quarterly	Half yearly	Yearly						
^3 months premium to be paid in advance and in	stalment/renewal premium paymen	t through NACH or standi	ng instruction (where	payment is made either by direct debit					
of bank account or credit card)									
IV. MEDICAL AND LIFESTYLE INFO	RMATION*:								

Мє	dical 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 Intestitial Lung Diseases or Pneumoconiosis or Emphysema.	YES NO	□YES □NO	□YES □NO	YES NO	YES 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.	YES NO	YES NO	YES NO	YES NO	YESNO
a.	Diabetes Mellitus	YES NO				
b.	Hypertension	YES NO				
C.	High Cholesterol	YES NO				
d.	Thyroid disorders (Goitre, Hyperthyroidism, Hypothyroidism, Thyroditis, any other)	YES NO	YES NO	YESNO	YES NO	YES 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)	YES 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)	YES 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)	YES NO	YES NO	YES NO	YES NO	YESNO
h.	Other Endocrine (Hormonal) disorders (Parathyroid gland disorders, Adrenal Disorder, Pituitary Disorders, any other)	YES NO	YES NO	YESNO	☐YES ☐NO	YES NO
i.	Bone, joints and muscle disorders (Gout / Hyperuricemia, steoarthiritis, Shoulder Dislocation, Spondylitis / Spondylosis, Osteoporosis, Prolapse of Inter-vertebral disc (disc prolapse), Total Knee Replacement, Total Hip Replacement, any other)	YES NO	YES NO	YESNO	YES NO	YES 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)	YES NO	YES NO	YESNO	YES NO	YESNO
k.	Genito-urinary and Gynaecological disorders (Kidney / bladder stones, Recurrent Urinary tract infection, Stricture Urethra, Cytitis/ 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)	YESNO	YES NO	YES NO	YES NO	YESNO
l.	Blood and related disorders (Anaemia, Thalassaemia, Sexually transmitted diseases, HIV / AIDS (Acquired Immuno-deficiency syndrome), any other)	YES NO	YES NO	YES NO	YES NO	YESNO
m.	Skin disorders (Psoriasis, Eczema, Dermatitis, Urticaria, Vitiligo, Cyst/lump/growth/polyp/tumour, any other)	YES NO	YES NO	YESNO	YES NO	YES NO
n.	Any other condition / illness / disorder / surgery	YES 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?	YES NO	YES NO	YES NO	YES NO	YESNO
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)?	YES NO	YES NO	YES NO	YESNO	YESNO

0
Ñ
눇
×
₹
픘
\approx
0
_
ш
ш
\circ
\lesssim
\simeq
ч.
S
>
7
رو
⋖
~
202
0
α
<u></u>
Z
\simeq
ゴ
_
156V011920 URN: 2021/AS/V2.02/OF
ಜ
ď
~
÷
0
>
9
Ω
$\overline{}$
20
ŭ
뜨
UIN: MCIHLIP20156
I
兲
\circ
≥
Ξ.
7
≡
\supset
_
Ø
ipalCigna UIN
ō
$\overline{\circ}$
\simeq
ā
.₽
П
σ
⋝
_
->
<u>ે</u>
Silo
Policy
_
_
_
_
_
_
_
_
_
_
_
_
_
_
anjeevani I

24

H.	ABITS 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	YES NO				
A.	Smoke	YES NO				
1.	Since how long does the applicant smoke					
a.	<=20 years (Tick if applicable)					
b.	>20 years (Tick if applicable)					
В.	Tobacco	YES NO				
1.	How many Pan masala / gutka packets does the applicant has in a day					
a.	1-3 packets/day (☑Tick if applicable)					
b.	4-6 packets/day (☑Tick if applicable)					
C.	>6 packets/day (☑Tick if applicable)					
C.	Alcohol	YES NO				
1.	How frequently does the applicant consume alcohol					
a.	1-3 days/ week (Tick if applicable)					
b.	3-6 days / week (☑ Tick if applicable)					
C.	Daily (☑Tick if applicable)					

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					

Si	ign	ıatι	ıre	of	Pr	ope	ose	er	*:	

(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:

Pease 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.	e.g. Mediclaim, PA,	Insurer Name	From Date	To Date	Sum Insured	Clai	m Details		ative Bonus arned
		CI, Hospital Cash					Claim Number	Claimed Amount	 %	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 I	Bonus Earned
						%	Amount
Insured 1							
Insured 2							
Insured 3							
Insured 4							
Insured 5							

202	
8	
α	
ī	
ē	
0	
ᅙ	
ಕ	
\simeq	
Ō	
Ŏ	
ш	
ш	
ō	
\sim	
Ñ	
$\dot{\circ}$	
αi	
>	
5	
ഗ	
à	
~	
$\overline{}$	
\sim	
202	
JRN: 2021/AS/V2.02/OFF	
~	
_	
ır	
$\overline{}$	
_	
20	
2	
co.	
~	
÷	
Ò	
\leq	
<u>~</u>	
ω	
S	
$\overline{}$	
20	
$^{\circ}$	
Λ	
_	
=	
무	
H H	
OIT LE	
ACIHLIP	
MCIHLIP	
: MCIHLIP	
N: MCIHLIP	
N: MCIHLIP	
UIN: MCIHLIP	
OIN: MCIHL	
// JanipalCigna UIN: MCIHLIP	
OIN: MCIHL	
ManipalCigna UIN: MCIHL	
ManipalCigna UIN: MCIHL	
ManipalCigna UIN: MCIHL	
ManipalCigna UIN: MCIHL	
olicy, ManipalCigna UIN: MCIHL	
olicy, ManipalCigna UIN: MCIHL	
olicy, ManipalCigna UIN: MCIHL	
ni Policy, ManipalCigna UIN: MCIHL	
ni Policy, ManipalCigna UIN: MCIHL	
ni Policy, ManipalCigna UIN: MCIHL	
ni Policy, ManipalCigna UIN: MCIHL	
ni Policy, ManipalCigna UIN: MCIHL	
ni Policy, ManipalCigna UIN: MCIHL	
ni Policy, ManipalCigna UIN: MCIHL	
anjeevani Policy, ManipalCigna UIN: MCIHL	
Sanjeevani Policy, ManipalCigna UIN: MCIHL	
Sanjeevani Policy, ManipalCigna UIN: MCIHL	
Sanjeevani Policy, ManipalCigna UIN: MCIHL	
Sanjeevani Policy, ManipalCigna UIN: MCIHL	
yya Sanjeevani Policy, ManipalCigna UIN: MCIHL	
ogya Sanjeevani Policy, ManipalCigna UIN: MCIHL	
ogya Sanjeevani Policy, ManipalCigna UIN: MCIHL	
yya Sanjeevani Policy, ManipalCigna UIN: MCIHL	
ogya Sanjeevani Policy, ManipalCigna UIN: MCIHL	

VIII. PAYMENT DETAILS*: Premium Paid by: Middle Last Relationship to Proposer: Premium Amount: in Words Debit Card Credit Card Payment Option: Cheque Pay Order Cash **Demand Draft** 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 Date: Instrument / Transaction Number: 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. Signature of Proposer *: (A policyholder or prospect, who is a person with disability, may duly authorize a representative to Date: give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)

X. 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 insurer 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/which at anytime has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured/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 of the insured/proposer for the sole purpose of underwriting the proposal 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 XI. 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) XII. INTERMEDIARY CONFIDENTIALITY REPORT*: (Full Name) 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 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 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 b Date: D D M M Y Y Y Place: Signature of Agent: Prohibition of Rebates (Under Section 41 of the Insurance Act, 1938): 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 insurer. 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) Received from Ms/Mrs/Mr through Cash#/Cheque/DD/Credit Card/Debit Card No a sum of ₹ against your proposal for XXX Policy Signature of ManipalCigna official / Intermediary: Date ManipalCigna official / Intermediary Name: Place: 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 Policy 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

Insurance is a subject matter of solicitation

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.