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

ManipalCigna Health Insurance

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:	Sub Intermediary PAN:	Other Details:

Ref. A
Ref. B

AROGYA SANJEEVANI POLICY, MANIPALCIGNA

(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

Date of Birth* : D D M M Y Y Y Y Marital Status*: Married ☐ Single ☐ Others ☐ is the Payor: ☐

Name* : F I R S T* M I D D L E L A S T*

Permanent Address* :

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):

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).

Office(Optional):

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_____ Other (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 : Document Expiry date: D D M M Y Y Y Y
(Please mention only last four digits of your Aadhaar or VID)

CKYC number : EIA number:

PEP or relative of PEP :

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

Arogya Sanjeevani Policy, ManipalCigna | UIN: MCIHLIP20156V011920 | URN: 2021/AS/V2.02/OFF | October 2024

Family Physician Details:

Name : FIRSTNAME MIDDLENAME SURNAME

Contact number : Email id:

Address :

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

Name* : FIRSTNAME* MIDDLENAME SURNAME*

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# 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 customercare@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 section 39 of the Insurance Act, 1938, as amended f me to time 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

III. POLICY/PLAN DETAILS*:

Tenure*: 1 Year ☐

Proposed Policy Period: From DD MM YYYY at : **Hrs**

(Must be on or later than instrument date/ premium payment date)

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

*Are all insured Indian National and Indian Residents? ☐ Yes ☐ No

If No, Please mention country _____

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 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	☐YES ☐NO
a.	Diabetes Mellitus	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
b.	Hypertension	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
c.	High Cholesterol	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
d.	Thyroid disorders (Goitre, Hyperthyroidism, Hypothyroidism, Thyroditis, any other)	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐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	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐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	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐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	☐YES ☐NO
h.	Other Endocrine (Hormonal) disorders (Parathyroid gland disorders, Adrenal Disorder, Pituitary Disorders, any other)	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐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	☐YES ☐NO	☐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	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
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)	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
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	☐YES ☐NO
m.	Skin disorders (Psoriasis, Eczema, Dermatitis, Urticaria, Vitiligo, Cyst/ lump/ growth / polyp / tumour, any other)	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
n.	Any other condition / illness / disorder / surgery	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐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	☐YES ☐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)?	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐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	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
A.	Smoke	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
1.	Since how long does the applicant smoke					
a.	<=20 years (☑ Tick if applicable)	☐	☐	☐	☐	☐
b.	>20 years (☑Tick if applicable)	☐	☐	☐	☐	☐
B.	Tobacco	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐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	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	☐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					

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:

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.	Type of Policy e.g. Mediclaim, 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 ☐ Demand Draft ☐ Pay Order ☐ Credit Card ☐ Debit Card ☐ Cash ☐

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

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)

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.

Date: D D M M Y Y Y Y **Place:** _____

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.

Date: D D M M Y Y Y Y **Place:** _____

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*:

I, _____ (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 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

a sum of ₹ through Cash#/Cheque/DD/Credit Card/Debit Card No. against your proposal for XXX Policy.

Signature of ManipalCigna official / Intermediary: Date:

ManipalCigna official / Intermediary Name:

Time: 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 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.

Insurance is a subject matter of solicitation

Arogya Sanjeevani Policy, ManipalCigna | UIN: MCIHLIP20156V011920 | URN: 2021/AS/V2.02/OFF | October 2024