posal Form No.:	 (Formerl Corpora Goregad 	Cigna Health Insur y known as CignaT ite Office: 401/402, on (E), Mumbai - 400 II Free): 1800-102-4	TK Health Ins Raheja Titan 0063. IRDAI F	iurance Con ium, Wester Registration	npany Limited n Express Hig No. 151.		<u>п</u>	Μ		ipe ealth Ir			ign
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ManipalCigna Lifestyle Protection - Critical Care Proposal Form | UIN: MCIHLIP21125V022021 | URN: 2020/LPCC/V2.03/OFF | October 2024

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 charge	9S.
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 h	ard 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 XI 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	
Form 60* (only in case where PAN number is not available) Yes No Identity Document Type : Aadhaar Card Driving License Passport Voter's ID car	d Others
	d Others
Identity Document Type : Aadhaar Card Driving License Passport Voter's ID car	d Others
Identity Document Type : Aadhaar Card Driving License Passport Voter's ID car Aadhaar number/ (VID number)^^:	d Others
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Identity Document Type : Aadhaar Card Driving License Passport Voter's ID car Aadhaar number/ (VID number)^^*: EIA number: EIA number: CKYC number EIA number: EIA number: PEP or relative of PEP: EIA number: EIA number: Family Physician Details: EIA number: EIA number: Name : FIRSTNAME MIDDLENA Contact number : Email id: Address : Identity Policy/ies: Yes No If Yes, please provide: Name* : FIRSTNAME*	

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

II. 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 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. *A Minor should not be declared as Appointee.

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III. POLICY/PLAN DETAILS*:

Tenure*: 1 Year	2 Years	3 Years	Proposed Policy Period: From	D	D	Μ	Μ	Y	
			(Must be on or later than instrument date	pren	nium	payn	nent	date))

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

Sr No.	Name (First*,Middle, Last*)	Gender* (M/F/O)	DOB*	Relationship with Proposer*	ABHA No.	Height* (Cms)	Weight* (Kgs)	Occupation/ Industry Type/ Nature of Job*	City*	Sum Insured*		Insured Address If Different From Proposer	If PEP/ Relatives of PEP^ (Y / N)		
1															
2															
3															
4															
5															
6															
7															
8															
^^^P Insu	P details are not provided, lease provide ABHA numb red Person, you may reque sured Indian national and India	er (Ayushman est to create a	n Bharat H n ABHA n	ealth Account n					e the ABHA n	umber is	not avail	able for any			
	, Please mention country														
Note	: ManipalCigna Lifestyle Protec	tion – Critical Ca	are: Minimu	m age at entry und	ler this pol	icy is 18 yea	rs and maxin	num age at entry is 65 ye	ars						
Pla	n Name*:					P	ayout Op	otion:		Polic	y Type:				
Bas	sic (15 Critical Illnesses	;) En	hanced	(30 Critical Illnesses) Lump Sum Staggered						Individual Family					
Applicable Discounts:															
	Family Discount of 10°		0												
	-ong Term policy disc Premium Policies.	ong Term policy discount of 7.5% and 10% on selecting a 2 and 3 years policy respectively. Long Term discount remium Policies.						t will ap	ply only	in case of S	ingle				
с. І	Direct Policy Discount	t of 10% if th	is Policy	is bought fror	n Us wi	thout any	intermedi	ary.							
d. [Worksite Marketin		-	-		,		nployee id:							
Pre	emium payment mode	: Monthl	y^	Quarterl	у	Half	yearly	Yearly	S	ingle					

[^]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.

ManipalCigna Health 360 [UIN: MCIHLIA23023V012223]

ManipalCigna Health	360 - OPD				
(Opt any one of the P	ackages below and Sum	Insured)			
Package 1	Package 2		Packa	ge 3	
₹5,000	₹10,000	₹50,000	₹20,00	00 ₹60,000	
₹10,000	₹15,000	₹60,000	₹25,00	00 ₹70,000	
₹15,000	₹20,000	₹70,000	₹30,00	00 ₹80,000	
₹20,000	₹25,000	₹80,000	₹40,00	00 ₹90,000	
	₹30,000	₹90,000	₹50,00	00 ₹100,000	
	₹40,000	₹100,000			

IV. MEDICAL AND LIFESTYLE INFORMATION*:

	dical questions	Incurac	1 Incured 2	Incured 2	Incured 4	Incured 5	Incured 6	Incured 7	Insured 8
Q1	Has any of the applicant ever been diagnosed with or suspected to have Cancer or Rheumatoid Arthritis or Ulcerative Colitis or Crohn's disease	Insured	1 Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	
	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.	NO	S YES	YES	YES	YES NO	YES NO	YES	YES
Q2	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.	YE:	B YES NO	YES NO					
i	Diabetes Mellitus		B YES NO	YES NO	YES	YES	YES	YES	YES
ii	Hypertension	YE		YES NO	YES NO	YES NO	YES	YES NO	YES
iii	High Cholesterol	YE		YES NO	YES	YES	YES	YES	YES
iv	Thyroid disorders	YE		YES NO	YES	YES	YES	YES	YES
v	Heart and Lung disorders		B YES NO	YES NO	YES NO	YES	YES NO	YES NO	YES
vi	Digestive system disorders (Stomach and related organs)		B YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
vii	Brain, nerve and Psychiatric (Mental) disorders		G YES	YES NO					
viii	Other Endocrine (Hormonal) disorders	YE:	S YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
ix	Bone, joints and muscle disorders	YE:	S YES NO	YES NO					
x	Ear, nose, eye and throat disorders	YE:	S YES NO	YES NO					
xi	Genito-urinary and Gynaecological disorders	YE:	S YES NO	YES NO					
xii	Blood and related disorders	YE:	S YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
xiii	Skin disorders	YE:	G YES NO	YES NO					
xiv	Any other condition / illness / disorder / surgery	VES NO	S YES	YES NO					
Q3	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?	VES NO	S YES	YES NO					
Q4	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)?		D NO	NO	YES NO	YES NO	YES	YES	YES
Ha	bits and Lifestyle questions	Insured	1 Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q5	Does any of the insured/s chew tobacco / smoke / consume alcohol? Please tick the relevant box(es) below	YE:		YES NO					
Α	Smoke	YES	S YES	YES NO					
1	Since how long does the applicant smoke								
а	<=20 years								
b	>20 years								
в	Торассо	YE:	B YES NO	YES NO					
1	How many Pan masala / gutka packets does the applicant has in a day					1			
1 a	How many Pan masala / gutka packets does the applicant has in a day 1-3 packets/day								
a	1-3 packets/day								

1	How frequently does the applicant consume alcohol								
а	1-3 days/ week								
b	3-6 days / week								
С	Daily								
Q6	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 NO	YES NO	YES NO	YES	YES NO	YES NO	YES NO

V. ADDITIONAL MEDICAL INFORMATION:

If answers to Q2 and 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:

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, Cl, Hospital Cash	Insurer Name	From Date	To Date	Sum Insured		laim Deta		Bonus	ulative Earned	Has any prop health, hospita critical illness ir life of the appli declined, post or been made special condit exclusions by comp	I daily cash or asurance on the cant ever been poned, loaded subject to any tions such as any insurance
							Claim Number	Claimed Amount	Ailment	%	Amount	(Y – Yes	/ N – No)
Insured 1												YES	NO
Insured 2												YES	NO
Insured 3												YES	NO
Insured 4												YES	NO
Insured 5												YES	NO
Insured 6												YES	NO
Insured 7												YES	NO
Insured 8												YES	NO

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></first>	<middle></middle>	<last></last>	Relationship to Proposer :	
Premium Amount :		i	in Words		
Signature :					
Payment Option: Cheque	Demand Draft	Pay Order	Credit Card	Debit Card	Cash
For Cheque / DD / Credit Carc Proposal form No.	d/ Debit Card/ PO/ Others (Pl	ease specify)	(Payable in favour of "	ManipalCigna Health Insuran	ce Company Limited" -
Instrument / Transaction Numl	ber :		_ Instrument/Transactio	n Date: D D M M	YYYY
Instrument /Transaction Amou	int :		_		
Bank Name	:				
Payment to be collected only from Pro	oposers 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:																	
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 give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)

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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.

Date: D

Signature of Proposer *:

D M M Y Y Y Y Place:	(A policyholder or prospect, who is a person with disability, may duly authorize a representative t give declaration on his/her behalf, if required. For further assistance, please visit nearest branch
	give decidation of money behavior required in an antion decidation, predect for near our required bit in a

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.

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. 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):

Date: D D M M Y Y Y

Place:

Signature of Agent:

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
	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 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 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. Insurance is a subject matter of solicitation.