

Photograph of Insured 1

Photograph of Insured 2

Photograph of Insured 3

Photograph of Insured 4

Photograph of Insured 5

Photograph of Insured 6

Photograph of Insured 7

Photograph of Insured 8

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

Ref. A

Ref. C

Ref. B

MANIPALCIGNA LIFESTYLE PROTECTION - CRITICAL CARE  
PROPOSAL FORM

- 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 is the Payor:   
Date of Birth\* : DD MM YYYY Marital Status\* : Married  Single  Others   
Name\*(as in bank account): F I R S T N A M E \* M I D D L E N A M E \* S U R N A M E \*  
Permanent Address\* (As per the KYC proof submitted):  
Landmark:  
City\*: Town (District):  
State\*: Pin Code\*:  
Gram Panchayat:  
Correspondence Address\*:  
If same as above, please tick here   
Landmark:  
City\* : Town (District):  
State\*: Pin Code\*:  
Gram Panchayat:  
Email Address\* : Address 1 Address 2  
Telephone Number(s) : Mobile\*: Residence (Optional):  
Office(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).

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   Others (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

Aadhaar number/ (VID number)\*\*:

CKYC number :  EIA number:

PEP or relative of PEP:

#### Family Physician Details:

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

Contact number :  Email id:

Address :

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

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

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 <sup>#</sup> 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](mailto: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.

<sup>#</sup>A Minor should not be declared as Appointee.

## III. POLICY/PLAN DETAILS\*:

Tenure*: 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/>	Proposed Policy Period: From <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> at <input type="text"/> : <input type="text"/> Hrs (Must be on or later than instrument date/ premium payment date)
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**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												

^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>

All insured Indian national and Indian residents? Yes  No

If No, Please mention country \_\_\_\_\_

**Note:** ManipalCigna Lifestyle Protection – Critical Care: Minimum age at entry under this policy is 18 years and maximum age at entry is 65 years

<b>Plan Name*:</b> Basic (15 Critical Illnesses) <input type="checkbox"/> Enhanced (30 Critical Illnesses) <input type="checkbox"/>	<b>Payout Option:</b> Lump Sum <input type="checkbox"/> Staggered <input type="checkbox"/>	<b>Policy Type:</b> Individual <input type="checkbox"/> Family <input type="checkbox"/>
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- Applicable Discounts:**
- a. **Family Discount** of 10% for covering more than 2 family members under the same policy.
  - b. **Long Term policy discount** of 7.5% and 10% on selecting a 2 and 3 years policy respectively. Long Term discount will apply only in case of Single Premium Policies.
  - c. **Direct Policy Discount** of 10% if this Policy is bought from Us without any intermediary.
  - d.  **Worksite Marketing Discount:** Worksite Code:  Employee id:

**Premium payment mode:**  Monthly^  Quarterly  Half yearly  Yearly  Single

^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 Packages below and Sum Insured)				
<input type="checkbox"/> Package 1	<input type="checkbox"/> Package 2		<input type="checkbox"/> Package 3	
<input type="checkbox"/> ₹5,000	<input type="checkbox"/> ₹10,000	<input type="checkbox"/> ₹50,000	<input type="checkbox"/> ₹20,000	<input type="checkbox"/> ₹60,000
<input type="checkbox"/> ₹10,000	<input type="checkbox"/> ₹15,000	<input type="checkbox"/> ₹60,000	<input type="checkbox"/> ₹25,000	<input type="checkbox"/> ₹70,000
<input type="checkbox"/> ₹15,000	<input type="checkbox"/> ₹20,000	<input type="checkbox"/> ₹70,000	<input type="checkbox"/> ₹30,000	<input type="checkbox"/> ₹80,000
<input type="checkbox"/> ₹20,000	<input type="checkbox"/> ₹25,000	<input type="checkbox"/> ₹80,000	<input type="checkbox"/> ₹40,000	<input type="checkbox"/> ₹90,000
	<input type="checkbox"/> ₹30,000	<input type="checkbox"/> ₹90,000	<input type="checkbox"/> ₹50,000	<input type="checkbox"/> ₹100,000
	<input type="checkbox"/> ₹40,000	<input type="checkbox"/> ₹100,000		

**IV. MEDICAL AND LIFESTYLE INFORMATION\*:**

Medical questions		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 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 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
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.	<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	<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	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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
ii	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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
iii	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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
iv	Thyroid 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
v	Heart and Lung 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
vi	Digestive system disorders (Stomach and related organs)	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
vii	Brain, nerve and Psychiatric (Mental) 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
viii	Other Endocrine (Hormonal) 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
ix	Bone, joints and muscle 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
x	Ear, nose, eye and throat 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
xi	Genito-urinary and Gynaecological 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
xii	Blood and related 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
xiii	Skin 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
xiv	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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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)?	<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	<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	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	<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	<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>A</b>	<b>Smoke</b>	<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	<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	>20 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B</b>	<b>Tobacco</b>	<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	<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	4-6 packets/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	>6 packets/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C</b>	<b>Alcohol</b>	<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	<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	3-6 days / week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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:**

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. Medicaid, PA, CI, Hospital Cash	Insurer Name	From Date	To Date	Sum Insured	Claim Details			Cumulative Bonus Earned		Has any proposal for life, health, hospital daily cash or critical illness insurance on the life of the applicant ever been declined, postponed, loaded or been made subject to any special conditions such as exclusions by any insurance company?  (Y – Yes / N – No)
							Claim Number	Claimed Amount	Ailment	%	Amount	
Insured 1												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 2												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 3												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 4												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 5												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 6												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 7												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 8												<input type="checkbox"/> YES <input type="checkbox"/> 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>	<Middle>	<Last>	Relationship to Proposer :	_____
Premium Amount	:	_____ in Words _____				
Signature	:	_____				
<b>Payment Option:</b>		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:		<input type="text" value="D"/> <input type="text" value="D"/>	<input type="text" value="M"/> <input type="text" value="M"/>
Instrument /Transaction Amount	:	_____				
Bank Name	:	_____				
Payment to be collected only from Proposers 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:	<input type="text"/>
IFSC / MICR Code:	<input type="text"/>
Name of the Bank:	<input type="text"/>
Account Holder Name:	<input type="text"/>

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:**

**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)



