ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai - 400063.
IRDAI Registration No. 151. **Call** (Toll Free): 1800-102-4461
Visit: www.manipalcigna.com **E-mail:** servicesupport@manipalcigna.com

ManipalCigna Health Insurance

Proposal Form No.: _____

FOR OFFICE USE

Branch Name*: _____ Branch Code: _____ Business Type: Urban/ Social/ Rural

Intermediary Name: _____ Sourcing Department: _____ Intermediary Code*: Agent Code / Broker Code / CA Code

Ops Tags Employee DMS Code*: ManipalCigna Employee DMS Code Partner Vertical Name*: Partner Business Vertical Code Partner Branch ID*: Partner Branch Code

MANIPALCIGNA GLOBAL HEALTH GROUP POLICY PROPOSAL FORM

1. This form should be filled by the Corporate or any person authorised by the Corporate to sign on their behalf.
2. Please fill the form in BLOCK LETTERS.
3. Please submit the proposal form in original, photo copies will not be accepted by the Company.
4. Kindly contact the Company's Office for any doubt or clarification on the Proposal Form.

Note: The liability of the Company does not commence until this proposal is accepted by the Company and premium received.

I. PROPOSER (CORPORATE) DETAILS:

All invoices will be raised to the following address and addressed to the Principle contact person mentioned below

Proposer Name : (First / Middle / Last)

Principle Contact Person's Name:

Types of Business:

Correspondence (Present) Address*: Block No./ Flat No.: Floor No.: Building Name:

Street Name: Locality:

Landmark:

City: Town (District):

State: Pin Code:

Country:

Permanent Address* : Block No./ Flat No.: Floor No.: Building Name:

Street Name: Locality:

Landmark:

City: Town (District):

State: Pin Code:

Country:

Contact Number : Landline: Mobile Number*:

E-mail Address* :

PAN No. / TAN No.^^ :

AADHAAR No.^^ : Customer GSTIN No. (if any):

Period of Insurance From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Please state whether all eligible employees/families, members/families of the Group / Association / Institution / Corporate Body are proposed for Insurance? Yes ☐ No ☐

Total Number of Employees/ Members to be covered (including families/ dependents wherever covered):

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

II. INSURED DETAILS:

Is the Address of insured different from that of the Proposer? ☐ **Yes** ☐ **No**

If Yes please provide address:

Please provide details of Insured Persons and of benefit and coverage required (Attach separate sheet with the following data elements)

Details	Insured 1	Insured 2
Unique identification No./ Employee No./ Membership No.		
Name of Insured member		
Relationship with the Proposer		
Relationship of the family members with the Employee/ Member		
Date of Birth		
Gender		
Height		
Weight		
Nationality		
ABHA#		
Earning/Non- earning		
Gainful Annual Income		
Passport No.		
Passport Expiry Date		
Profession/ Nature of Duty/ Occupation		
Designation/ Category/ Position		
Out of Country Location		
Date of Enrollment / Joining		
Trip Start date/ Coverage Commencement Date		
Trip End Date		
No. of Travel days		
City of origin		
Place of residence		
Area/s of Cover		
Overseas Address		
Visa Type (Immigrant/ Non-immigrant)		
Visa Validity (From – To)		
Purpose of Visit (Business/ Holiday/ Studies/ Others (specify))		
Email ID		
Mobile No.		
Pre-existing Diseases		
<< Any Medical information which you may want insurer to know?>>		
Plan/ Base Cover/s		
Sum Insured		
Deductible and other limits, Sub Limits and condition		
Optional Covers		
Sum Insured		
Deductible and other limits, Sub Limits and condition		

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	Present 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# Relationship with Nominee			

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.

MEDICAL & LIFE STYLE INFORMATION: (The list is indicative and questions may be added or deleted depending on group basis UW requirement)	Insured 1	Insured 2
Are You suffering from or have You ever suffered from any of the following (please encircle): musculoskeletal diseases, arthritis, disorders of the spinal cord or vertebral column like slipped disc, osteoporosis, disease of bones/ joints etc, circulatory disorder, high blood pressure, heart condition, varicose veins, etc, cancer of any kind, tumor, cyst, ulcer, endocrine disorders, diabetes, thyroid, etc, digestive or gastrointestinal digestive or gastrointestinal disorders, liver disorder, hernia of any kind, hemorrhoids, fistula, hematological (blood) disorder, mental / Psychiatric condition, nervous disorder, fainting episode, blackouts, fits, paralysis of any kind, respiratory disorder, kidney or urinary tract disorder, ENT, eye, dental, allergies, skin disorder, gynecological and breast disorder, alcohol or drug abuse or any diseases or injury requiring surgical or medical treatment.	Yes ☐ No ☐ If Your answer is 'yes' to any of the above, please provide details: _____ _____ _____	Yes ☐ No ☐ If Your answer is 'yes' to any of the above, please provide details: _____ _____ _____
Do you have any physical deformity, any pre-existing illness / disease / injury / disability / physical or mental illness (psychiatric, sleep disorders) / or any condition that may affect mobility / sight / hearing / speech?	Yes ☐ No ☐ If Your answer is 'yes' to any of the above, please provide details: _____ _____	Yes ☐ No ☐ If Your answer is 'yes' to any of the above, please provide details: _____ _____
Have you ever been hospitalized for treatment/ observation/ /recommended to take investigation/ surgery?	Yes ☐ No ☐ If Your answer is 'yes' to any of the above, please provide details: _____ _____	Yes ☐ No ☐ If Your answer is 'yes' to any of the above, please provide details: _____ _____
Are you currently or in past were on medication? Have you suffered from any illness or had an Accident in the preceding 12 months?	Yes ☐ No ☐ If Your answer is 'yes' to any of the above, please provide details: _____ _____ Yes ☐ No ☐ If Your answer is 'yes' to any of the above, please provide details: _____ _____ _____	Yes ☐ No ☐ If Your answer is 'yes' to any of the above, please provide details: _____ _____ Yes ☐ No ☐ If Your answer is 'yes' to any of the above, please provide details: _____ _____ _____
Have you recently (within 60 days) taken any health check-up?	Yes ☐ No ☐ If Your answer is 'yes' please attach report. _____ _____ _____	Yes ☐ No ☐ If Your answer is 'yes' please attach report. _____ _____ _____
Has any application for life or health ever been declined, postponed, loaded or been made subject to any special conditions by the company or any insurance company?	Yes ☐ No ☐ If Your answer is 'yes' please attach report. _____ _____ _____	Yes ☐ No ☐ If Your answer is 'yes' please attach report. _____ _____ _____

III. PLAN DETAILS:

Note: Additional insurances (optional covers) can be purchased only in addition to a core plan and not separately. All elements can be chosen per expat group. In case of multiple plans/sum insured requirements please mention the details against each member/family in the attached format.

Please select the required plan(s) (if multiple plans are required for different sets of employees, please fill the relevant plan in the Insured Details section):

Plan Name	<<Plan name with Plan specific criteria- SI, Covers, Eligibility, etc>>
Policy Tenure	1 Year
No. of Travel days <<For corporate Policy>>	
Cover Type	<<Individual >>
Sum Insured/s	<<Currency>> <<Amount>>
Area/s of Cover	<< Area of Cover>>

Base Cover/s (Sum Insured, Sub Limit, Deductible/ Sub-limit/ Waiting Period/ Other Limits & Conditions)	Name of the Cover	Sum Insured	Aggregate Limit (if opted)	Sub-limits/ Sub- options	Deductible/s	Co-pay	Other Limits & Conditions
Optional Cover/s (Sum Insured, Sub Limit, Deductible/ Sub-limit/ Waiting Period/ Other Limits & Conditions)	Name of the Cover	Sum Insured	Aggregate Limit (if opted)	Sub-limits/ Sub- options	Deductible/s	Co-pay	Other Limits & Conditions

Sr. No.	Name of the Waiting Period <<as applicable>>	Waiting Period <<as opted>>
<< >>	<< >>	<< >>
<< >>	<< >>	<< >>
<< >>	<< >>	<< >>

IV. DETAILS OF PREVIOUS INSURER(S) (If renewal):

Are your employees/members at present insured under any Domestic / International Health Insurance? Yes ☐ No ☐

If 'Yes' Please provide the details of insurer, type of policy with coverage & sum insured-(attach additional sheet if required)

Name of Insurer:

Policy Number :

Expiring Terms of cover:

Period of Insurance:

Premium paid:

Claim details: (Please attach separate sheet providing complete details of claims with individual claim records)

Incurred Claims Ratio:

Note: Ensure that the information in this form material for assumption of risk is accurate and complete as inaccuracy or non-disclosure of the requested information or other material facts could preclude recovery of any claim under the policy.

V. Current Insurance Details

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							

VI. Premium payment details (Please provide the details of premium payment):

Premium Amount (INR): _____

Payment Option (please tick (✓)): ☐ Cheque ☐ DD ☐ Other (Specify) _____

Amount in words _____

Payment Frequency : ☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Yearly

For Cheque / DD (Payable in favour of "ManipalCigna Health Insurance Company Limited")

Instrument No.: _____ Instrument Date: D D M M Y Y Y Y

Instrument Amount: _____

Bank Name: _____

Name of Premium Payer: _____

VII. DECLARATION & AUTHORIZATION:

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 authorized to propose on behalf of these other persons. I/We will maintain details of all the individual members covered, which shall also be made available to the insurance company as and when required.

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 any time 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.

☐ I consent to and authorize 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 authorized 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

Time: _____ **Place:** _____

Signature of Proposer

VIII. 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 Y **Time:** _____ **Place:** _____

Signature of Corporate 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 out 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 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 prospectus or tables of the insurers.

2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

INSURANCE IS A SUBJECT MATTER OF SOLICITATION

Note: Proposal form shall be used for group policy and it shall be customized as per the coverage and benefits offered under the product for the group as per their requirement

BANK ACCOUNT DETAILS

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:

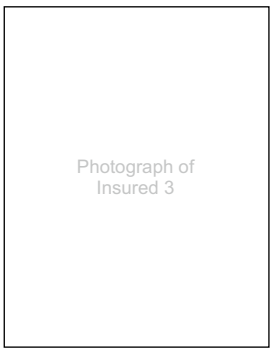
- It is important for these electronic payment systems that the Policy Holder's name in the Policy must exactly match with the name in the Bank Account records/details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For 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.

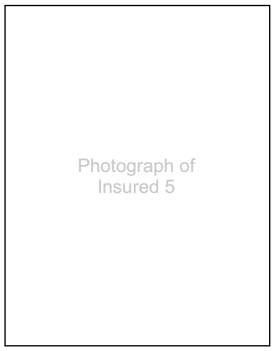
Date: D D M M Y Y Y Y

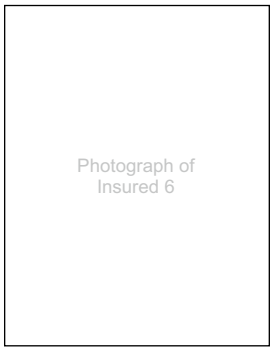
Signature of Proposer/Authorized Representative*:_____

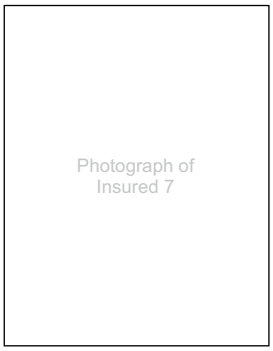
(A policyholder or prospect, who is a person with disability, may duly authorize a representative to give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)

Annexure - A
KYC of Beneficial owners









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: ☐

Beneficial Owner Name*: (as in bank account) F I R S T* M I D D L E L A S T*

Permanent Address : (As per the KYC proof submitted)
Address 1: Address 2:
Landmark:
City*: Town (District):
State*: Pin Code*:

Present Address* :
Address 1: Address 2:
Landmark:
City*: Town (District):
State*: Pin Code*:

Email Address* : Address 1: Address 2:

Telephone Number(s) : Mobile*: Residence (Optional):
Office(Optional):

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

CKYC number : EIA number:

PEP or relative of PEP :

ManipalCigna Global Health Group Policy | Proposal Form | UIN: MCIHLGP21247V032021 | URN: 2020/CGHB/V3.02 | October 2024