



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:<<For POSP>> Sub Intermediary PAN:<<For POSP>> Other Details:<<For POSP>>

Ref. A

Ref. B

MANIPALCIGNA LIFETIME HEALTH 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 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  2 Years  3 Years  Proposed Policy Period: From           at :  Hrs  
 (Must be on or later than instrument date/ premium payment date)

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)

**India Plan:**  
 Sum Insured<sup>1</sup> option\*:  ₹50 Lacs  ₹75 Lacs  ₹1 Crore  ₹1.5 Crores  ₹2 Crores  ₹3 Crores  
 (Please select the Sum Insured you wish to opt for; Sum Insured<sup>1</sup> is coverage available under benefits from II.1 to II.15 of the Prospectus)

**Global Plan**  
 Sum Insured<sup>2</sup> option\* (Mandatory if benefits under Global Plan is selected):  
 ₹50 Lacs  ₹75 Lacs  ₹1 Crore  ₹1.50 Crores  ₹2 Crores  ₹3 Crores  
 (Please select the Sum Insured you wish to opt for; Sum Insured<sup>2</sup> is coverage available under benefits from II.16 to II.25 of the Prospectus)

**Major Illness option\***(Mandatory if benefits under Global Plan is selected):  
 Only Cancer treatment  
 All Major Illnesses

**Area of Cover option\*** (Mandatory if benefits under Global Plan is selected):  
 Worldwide excluding India  
 Worldwide excluding India, USA and Canada

**ManipalCigna Lifetime Plus - Cumulative Bonus** (Applicable only on India SI - SI1 of ManipalCigna Lifetime Health)

**ManipalCigna - Lifetime Plus - Worldwide Medical Emergency Hospitalization**  
 Can be opted only if all Insureds are Indian national and Indian residents  
 Sum Insured (Option to select)  
 25 Lacs  50 Lacs  1 Crore

**Area of Cover option\***  
 Worldwide excluding India  
 Worldwide excluding India, USA and Canada  
 \*To be selected if opted with India Plan, In case of Global Plan, the Area of cover of the Underlying Policy shall apply for this cover.

**ManipalCigna Critical Illness Add On Cover [UIN: MCIHLIP21128V022021]**

**ManipalCigna Health 360 [UIN: MCIHLIA23023V012223]**

<input type="checkbox"/> ManipalCigna Health 360 - Shield	<input type="checkbox"/> ManipalCigna Health 360 - Advance	<input type="checkbox"/> ManipalCigna Health 360 - OPD (Opt any one of the Packages below and Sum Insured)		
Non-Medical Items	Restoration of Sum Insured	<input type="checkbox"/> Package 1	<input type="checkbox"/> Package 2	<input type="checkbox"/> Package 3
Durable Medical Equipment	Room Accommodation Upgrade	<input type="checkbox"/> ₹5,000	<input type="checkbox"/> ₹10,000	<input type="checkbox"/> ₹20,000
	Air Ambulance	<input type="checkbox"/> ₹10,000 <input type="checkbox"/> ₹15,000 <input type="checkbox"/> ₹20,000	<input type="checkbox"/> ₹15,000 <input type="checkbox"/> ₹20,000 <input type="checkbox"/> ₹25,000 <input type="checkbox"/> ₹30,000 <input type="checkbox"/> ₹40,000 <input type="checkbox"/> ₹50,000 <input type="checkbox"/> ₹60,000 <input type="checkbox"/> ₹70,000 <input type="checkbox"/> ₹80,000 <input type="checkbox"/> ₹90,000 <input type="checkbox"/> ₹100,000	<input type="checkbox"/> ₹25,000 <input type="checkbox"/> ₹30,000 <input type="checkbox"/> ₹40,000 <input type="checkbox"/> ₹50,000 <input type="checkbox"/> ₹60,000 <input type="checkbox"/> ₹70,000 <input type="checkbox"/> ₹80,000 <input type="checkbox"/> ₹90,000 <input type="checkbox"/> ₹100,000

**ManipalCigna Lifetime Plus [UIN: MCIHLIA24148V012324]**

<input type="checkbox"/> <b>ManipalCigna Lifetime Plus - Maternity Expenses</b>  <b>Optional Cover:</b> <input type="checkbox"/> Infertility Cover (Option to select only if Maternity Expenses is opted)	<input type="checkbox"/> <b>ManipalCigna Lifetime Plus -Surrogacy Cover</b>  This cover can be opted only with 3 year policy term (The Sum insured for Surrogacy cover of ₹1 Lac is the overall limit available for the policy period of three years)	<input type="checkbox"/> <b>ManipalCigna Lifetime Plus - Oocyte Donor Cover</b>  (The Sum insured for Oocyte Donor cover of ₹1 Lac is available for every policy year)
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**IV. OPTIONAL PACKAGES:**

**Health+**
 **Women+** (Available for female Insured person above 12 years)
  **Global+**

**Discounts:**

- Long term discount:** (Applicable only with Single premium payment mode) 7.5% and 10% discount on the premium applicable for a policy term of 2 and 3 years respectively.
- Worksite marketing discount** Tick  if applicable  
 Worksite Code: \_\_\_\_\_ Employee id: \_\_\_\_\_
- Family discount:** (Applicable only with cover on individual basis) 15% discount on the premium is applicable for covering 2 or more members under a Policy. This discount is not applicable for Health+ and Women+ optional packages.
- Online Renewal discount:** 3% discount on the renewal premium, if the renewal premium is received through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card)
- Loyalty discount:** 5% discount on the entire Policy premium from 4<sup>th</sup> to 7<sup>th</sup> policy year and 10% discount on the premium of the entire Policy from 8th policy year onwards.

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

^3 months premium to be paid in advance and installment/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.

**V. INSURED DETAILS\*:** (Sum Insured only for individual cover)

Particulars		Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5
Name (First*, Middle, Last*)						
Gender*						
DOB*						
Relationship with Proposer*						
ABHA Number^^^						
Height* (Cms)						
Weight* (Kgs)						
Gainful Annual Income*						
Occupation/ Industry Type/ Nature of Job*						
City*						
Sum Insured* (only for individual cover)	Benefits covered undue Sum Insured <sup>1</sup>					
	ManipalCigna Critical Illness Add On Cover					
	Benefits covered undue Sum Insured <sup>2</sup>					
Maternity Expenses						
Infertility Cover (Option to select only if Maternity Expenses is opted)						
Surrogacy Cover						
Oocyte Donor Cover						
Insured address if different from Proposer						
PEP ^ (Yes/ No)						

^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 \_\_\_\_\_

**Note:** ManipalCigna Critical Illness Add On Cover: Minimum age at entry under this policy is 18 years and maximum age at entry is 65 years.

## VI. MEDICAL AND LIFESTYLE INFORMATION\*:

Please answer the below mentioned questions in Yes (Y) / No (N). If the answer to any of the questions is Yes, please provide complete details in the table for additional medical 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.>> (If Yes, tick against the disease)	<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	Cancer	<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	Rheumatoid Arthritis / Ulcerative Colitis / Crohn's disease	<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	Chronic Liver Disease, Hepatitis B, Cirrhosis	<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	Chronic Kidney Disease / Kidney failure	<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	Diseases of the Brain - Epilepsy/Fits/Stroke/Paralysis/Parkinsonism /Alzheimer's/Multiple sclerosis/Brain Tumor/ Cerebral Palsy	<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	Diseases of Heart - Heart Failure/Heart Attack/Angina/Coronary Artery Disease/Ischemic Heart Disease	<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	Chronic diseases of the Lungs - Chronic Bronchitis/ Intestinal Lung Diseases/ Pneumoconiosis/ 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	<b>Diabetes Mellitus</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 does the applicant manage his/her diabetes / pre-diabetes?								
a	Insulin	<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	Oral diabetic medication	<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	No medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Any other treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	How many medicines does the applicant take to manage his/her diabetes / pre-diabetes?								
a	No medicine	<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	One medicine	<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	Two medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Three or more medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	When was the applicant first diagnosed with diabetes / pre-diabetes?								
a	1 - 5 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	5 - 10 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"/>
c	10 - 15 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"/>
d	More than 15 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"/>
ii	<b>Hypertension</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 does the applicant manage his/her Hypertension / High Blood Pressure?								
a	No medicine	<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	One medicine	<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	Two medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Three or more medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	When was the applicant first diagnosed with Hypertension / High Blood Pressure?								
a	1 - 5 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	5 - 10 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"/>
c	10 - 15 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"/>
d	More than 15 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"/>
iii	<b>High Cholesterol</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	Is any of the applicant under medication for high cholesterol / high triglycerides								

a	Yes	<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	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv	<b>Thyroid disorders</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	Which thyroid disorder is the applicant suffering from?								
a	Goitre	<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	Hyperthyroidism (high thyroid activity)	<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	Hypothyroidism (low thyroid activity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Other thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Thyroid Nodule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Thyroiditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Any other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v	<b>Heart and Lung disorders</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	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Upper Respiratory Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Lower Respiratory Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	DVT (Deep vein thrombosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Syncope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Hypotension (Low Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Varicocele	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Lung Abscess	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Allergic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Any other heart and lung condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi	<b>Digestive system disorders (Stomach and related organs)</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	Peptic ulcer (Ulcer in stomach or duodenum)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Cholecystitis/Cholelithiasis (Gall Bladder stones)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Hemorrhoids(Piles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Anal Fissure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Anal Fistula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Umbilical Hernia (Hernia at navel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Inguinal Hernia (Hernia in groin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Fatty liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Any other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vii	<b>Brain, nerve and Psychiatric (Mental) disorders</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	Recurring or severe headaches / Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Febrile Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Vertigo (Recurrent dizziness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Any other psychological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Dementia (Memory loss)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Attention deficit Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Any other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
viii	<b>Other Endocrine (Hormonal) disorders</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	Parathyroid gland disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Adrenal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Pituitary Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ix	<b>Bone, joints and muscle disorders</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	Gout / Hyperuricemia (high uric acid in blood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Shoulder Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Spondylitis / Spondylosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Prolapse of Inter-vertebral disc (disc prolapse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Total Knee Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Total Hip Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Any other	<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>x</b>	<b>Ear, nose, eye and throat disorders</b>	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
		<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO
1	Otitis-media (middle ear infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Nasal Polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Deviated Nasal Septum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Pharyngitis (throat infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Vocal Cord Nodule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Any other	<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>xi</b>	<b>Genito-urinary and Gynaecological disorders</b>	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
		<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO
1	Kidney / bladder stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Recurrent Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Stricture Urethra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Cytitis/ Infection of urinary bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Benign Hypertrophy of Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Hydrocele	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Torsion of testes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Phimosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Breast lump / Cyst / abscess	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Ovarian cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Fibroid Uterus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Menstrual disorder / irregular or excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Bartholin's abscess / cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Vaginal prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Cervical polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Any other	<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>xii</b>	<b>Blood and related disorders</b>	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
		<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO
1	Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Thalassaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	HIV / AIDS (Acquired Immuno-deficiency syndrome)	<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>xiii</b>	<b>Skin disorders</b>	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
		<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO
1	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Urticaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Cyst/ lump/ growth / polyp / tumour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Any other	<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>xiv</b>	<b>Any other condition / illness / disorder / surgery</b>	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
		<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<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
<b>Habits and Lifestyle questions</b>		<b>Insured 1</b>	<b>Insured 2</b>	<b>Insured 3</b>	<b>Insured 4</b>	<b>Insured 5</b>	<b>Insured 6</b>	<b>Insured 7</b>	<b>Insured 8</b>
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"/>
<b>For Lifestyle Protection – Critical Illness Add On Cover</b>		<b>Insured 1</b>	<b>Insured 2</b>	<b>Insured 3</b>	<b>Insured 4</b>	<b>Insured 5</b>	<b>Insured 6</b>	<b>Insured 7</b>	<b>Insured 8</b>
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

## VII. 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)



**VIII. PREVIOUS 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. Medclaim, 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?
							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

**IX. 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'.

**X. 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="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>	
Instrument /Transaction Amount	:	_____					
Bank Name	:	_____					
Payment to be collected only from Proposers Card/Bank Account							



**XII. 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 NCPDR/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:             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)

**XIII. 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:             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)

**XIV. ADVISOR / INTERMEDIARY DECLARATION\*:**

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 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:             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 out 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 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 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.**