posal Form No.:	(Formerl — Corpora Goregac Call (To	Cigna Health Insurar y known as CignaTTK te Office: 401/402, Ra on (E), Mumbai - 40006 Il Free): 1800-102-446 customercare@manip					
Photograph of Insured 1		Photograph of Insured 2		Photo	graph of ured 3		Photograph of Insured 4
Photograph of Insured 5		Photograph of Insured 6			graph of ured 7		Photograph of Insured 8
			FOR OFFICE US	E ONLY			
anch Name:				Branch Cod	e:		
ermediary Name:				Intermediar	y Code: Agent Co	de / Broker Code / CA Co	de
bs Tags: Employee DM b Intermediary Name:<	MS Code: ManipalCig	MANIPA	Partner Vertical N Sub Intermediary	PAN:< <for posp<="" th=""><th>>></th><th>Partner Branch ID Other Details:<<f Ref. C</f </th><th>: Partner Branch Code or POSP>></th></for>	>>	Partner Branch ID Other Details:< <f Ref. C</f 	: Partner Branch Code or POSP>>
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ManipalCigna Lifetime Health | Proposal Form | UIN: MCIHLIP21559V012021 | URN: 2024/LFHL/V1.0324 | October 2024

Would you like to sub	scribe to	import	ant ale	ert on V	Whatsa	app?	Yes	S	No														
Policyholders have th	e option	to acce	ess the	ir Poli	cy doc	umen	its thr	ough [DigiLocl	ker with	n no a	additional cha	irges.										
To learn more about I	DigiLock	er, plea	se visit	t https	://www	.mani	ipalci	gna.co	m/vide	o/													
Would you prefer to r	eceive a	ll policy	docum	nent d	igitally	(via e	email/	soft co	opy)?														
Yes (I would like	to recei	ve polic	y docu	ument	digital	y).	N	o (I pr	efer to r	eceive	polic	y document i	n hard	copy	/).								
Occupation*	: G	overnm	ient Se	ervice		Priva	ate Se	ervice		Self E	Emplo	yed	0	thers	5								
Annual Income*	Annual Income* : Up to ₹50,000				₹5 to ₹10 Lacs ₹15 to ₹20 Lacs																		
	₹5	0,000 tc) ₹5 La	CS		₹10	to ₹1	5 Lacs	;	Above	e ₹2) Lacs											
Educational Qualifica	tion* : Le	ess thar	ו class	Х		Clas	s X		Clas	s XII		Graduate	Р	ost G	Gradua	ate	F	rofes	siona	l Deç	jree		
Customer Goods & S	ervice Ta	ax Idenf	tificatio	n Nur	nber (il	fany)	:																
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PAN Card Number*	:																						
Form 60* (only in cas	e where	PAN nu	umberi	is not	availal	ble) Y	/es		No														
Aadhaar number^^/ (VID num	iber) :																					
EIA number:												PEP or rel	ative o	of PEI	P:								
CKYC number:																							
Family Physician De	etails:																						
Name	:	F			ΤΝ	A	ME		M			L E N A	M	Е				N /	A M	Е			
Contact number	:									Email	l id:												
Address	:																						
Do you wish to assig	n a Care	giver fo	r your l	Policy	/ies:	Yes		No	lf Y	es, ple	ase p	orovide:									-		
Name*	:	F	IR		ΤN	A	ME	*	M	I D	D	L E N A	M	E				N /	A M	E*			
Mobile number*	:										F	elationship w	ith Pro	opose	ər:								
Age (in Years)	:										E	mail id:											
Caregiver can be a close f	amily men	iber who	would ta	ke care	of the li	nsured	Perso	n in any	kind of h	ealth car	re evei	nt, whether emer	gency o	r planı	ned. Th	ie Careg	iver mię	ght not	be the	SOS	contac	<u>!</u> .	
^^Please provide the details	to enable	us to ser	ve you b	etter.																			

II. NOMINEE DETAILS*:

Is the Nominee same as Caregiver (if provided above)? 🗌 Yes 📃 No. If No, please provide Nominee details.

S. No.	Particulars	Nominee 1	Nominee 2	Nominee 3
1	Name			
2	Age			
3	Mobile No.			
4	Email ID			
5	Correspondence Address			
6	Permanent Address			
7	Relationship with Proposer			
8	Specify the percentage (%) of the claim amount payable to each nominee in the event of the policyholder's death. The total percentage of contribution across all the nominee must not exceed 100%			
9	Bank Details of Nominee Account No. IFSC/MICR Code Name of Bank Account Holder Name			
10	Appointee Details (Required only if nominee is a minor) Name Age [#] Mobile No. E-mail ID Relationship with Nominee			

As per recent regulatory mandate, nomination details are mandatory to be provided by the customers. lease provide your nominee details urgently by emailing us at <u>customercare@manipalcigna.com;</u> contacting us on 1800-102-4462, or visit our nearest branch.

In the event of death of the Proposer, any payment due under the Policy shall become payable to the nominee, as per the 'Nomination' clause defined by the IRDAI and the receipt of the proceeds by such nominee would be sufficient discharge to the Company. For all other persons covered under the Policy, the Proposer will be the nominee. A Minor should not be declared as Appointee.

III. POLICY/PLAN DETAILS*:

Tenure*: 1 Year 2 Years 3 Years	Proposed Policy Period: From D D M M Y Y Y Y at Hrs
	(Must be on or later than instrument date/ premium payment date)
Plan Type*: Individual Floater Port	tability: Yes No (If yes portability form to be completed and attached) Migration: Yes No (If yes migration form to be

ManipalCigna Health 360 [UIN: MCIHLIA23023V012223]

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

ManipalCigna Lifetime Plus - Maternity Expenses	ManipalCigna Lifetime Plus – Surrogacy Cover	ManipalCigna Lifetime Plus – Oocyte Donor Cover	ManipalCigna - Lifetime Plus - Worldwide Medical Emergency
	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)	(The Sum insured for Oocyte Donor cover of ₹1 Lac is available for every policy year)	Hospitalization Can be opted only if all Insureds are Indian national and Indian residents Sum Insured (Option to select) ₹25 Lacs ₹50 Lacs ₹1 Cr
			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.

IV. OPTIONAL PACKAGES:

Health+ Women+ (Available for female Insured person above 12 years) Global+
Discounts:
1. 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.
2. Worksite marketing discount Tick 🗸 if applicable
Worksite Code: Employee id:
3. 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.
4. 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)
5. Loyalty discount: 5% discount on the entire Policy premium from 4 th to 7 th 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)

Particular	S	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5
Name (First*, Mi	ddle, Last*)					
Gender*						
DOB*						
Relations	nip with Proposer*					
ABHA Nu	mber^^^					
Height* (0	Cms)					
Weight* (Kgs)					
Gainful A	nnual Income*					
Occupatio	on/ Industry Type/ Nature of Job*					
City*						
Sum Insured*	Benefits covered undue Sum Insured ¹					
(only for individual	ManipalCigna Critical Illness Add On Cover					
cover)	Benefits covered undue Sum Insured ²					
Maternity	Expenses					
Infertility ((Option to	Cover select only if Maternity Expenses is opted)					
Surrogac	/ Cover					
Oocyte D	onor Cover					
Insured a	ddress if different from Proposer					
PEP ^ (Ye	es/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.

Me	dical questions	Insu	red 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 arthritis="" b,="" chronic="" chronic<="" cirrhosis="" colitis="" crohn's="" disease="" disease,="" hepatitis="" liver="" or="" rheumatoid="" td="" ulcerative=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></cancer>									
	Kidney Disease or Kidney failure or Epilepsy or Fits or Stroke or Paralysis or Parkinsonism or Alzheimer's or Multiple sclerosis or Brain		YES							
	Tumor or Cerebral Palsy or Heart Failure or Heart Attack or Angina or Coronary Artery Disease or Ischemic Heart Disease or Chronic Bronchitis or Intestitial Lung Diseases or Pneumoconiosis or Emphysema.>> (If Yes, tick against the disease)		NO							
i	Cancer		YES NO	YES NO	YES NO					
	Rheumatoid Arthritis / Ulcerative Colitis / Crohn's disease		YES							
ii	Rieumatold Artimus/ Olcerative Collus/ Cronn's disease		NO							
iii	Chronic Liver Disease, Hepatitis B, Cirrhosis		YES NO	YES	YES NO	YES NO	YES	YES	YES NO	YES NO
			YES							
iv	Chronic Kidney Disease / Kidney failure		NO							
v	Diseases of the Brain - Epilepsy/Fits/Stroke/Paralysis/Parkinsonism /Alzheimer's/Multiple sclerosis/Brain Tumor/ Cerebral Palsy		YES NO	YES NO						
vi	Diseases of Heart - Heart Failure/Heart Attack/Angina/Coronary Artery Disease/Ischemic Heart Disease		YES NO	YES NO						
vii	Chronic diseases of the Lungs - Chronic Bronchitis/ Intestitial Lung Diseases/Pneumoconiosis/Emphysema		YES NO	YES	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Q2	Has any member ever suffered or currently suffering from or under		YES							
	treatment (operated, hospitalised, investigated) or been under medication for more than a week for any medical condition.		NO							
			YES							
i	Diabetes Mellitus		NO							
1	How does the applicant manage his/her diabetes / pre-diabetes?		_							
а	Insulin									
b	Oral diabetic medication									
С	No medicine									
d	Any other treatment									
2	How many medicines does the applicant take to manage his/her diabetes / pre-diabetes?									
а	No medicine									
b	One medicine									
С	Two medicines									
d	Three or more medicines									
3	When was the applicant first diagnosed with diabetes / pre- diabetes?									
a	1-5 years									
b	5-10 Years		_							
C	10 - 15 years		_							
d	More than 15 Years		YES							
ii	Hypertension		NO							
1	How does the applicant manage his/her Hypertension / High Blood Pressure?									
а	No medicine									
b	One medicine									
с	Two medicines									
d	Three or more medicines									
2	When was the applicant first diagnosed with Hypertension / High Blood Pressure?									
а	1-5 years									
b	5-10 Years									
с	10 - 15 years									
d	More than 15 Years									
111	High Cholesterol		YES NO	YES						
1	Is any of the applicant under medication for high cholesterol / high triglycerides									

ManipalCigna Lifetime Health | Proposal Form | UIN: MCIHLIP21559V012021 | URN: 2024/LFHL/V1.0324 | October 2024

						1			
а	Yes								
b	No								
	Thursdalla and an	YES	YES	YES	YES	YES	YES	YES	YES
iv	Thyroid disorders	NO	NO	NO	NO	NO	NO	NO	NO
1	Which thyroid disorder is the applicant suffering from?								
а	Goitre								
b	Hyperthyroidism (high thyroid activity)								
c	Hypothyroidism (low thyroid activity)								
d	Other thyroid disorders								
е	Thyroid Nodule								
f	Thyroditis								
g	Anyother]							
		YES	YES	YES	YES	YES	YES	YES	YES
v	Heart and Lung disorders	NO	NO	NO	NO	NO	NO	NO	NO
1	Asthma								
2	Tuberculosis								
3	Upper Respiratory Tract Infection								
4	Lower Respiratory Tract Infection								
5	Varicose veins								
6	DVT (Deep vein thrombosis)								
7	Syncope								
8	Hypotension (Low Blood Pressure)								
9	Varicocele								
10	LungAbscess								
11	Allergic Bronchitis								
12	Any other heart and lung condition								
		YES	YES	YES	YES	YES	YES	YES	YES
vi	Digestive system disorders (Stomach and related organs)	NO	NO	NO	NO	NO	NO	NO	NO
1	Peptic ulcer (Ulcer in stomach or duodenum)								
2	Appendicitis								
3	Cholecystitis/Cholelithiasis (Gall Bladder stones)								
4	Hemorrhoids(Piles)								
5	Anal Fissure								
6	Anal Fistula								
7	Pancreatitis								
8									
9	Umbilical Hernia (Hernia at navel)								
10	Umbilical Hernia (Hernia at navel) Inguinal Hernia (Hernia in groin)								
11	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome								
	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver								
11 12	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome								
	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver								
12 vii	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders	 					U U	U U	
12 vii 1	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine								
12 vii 1 2	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions								
12 vii 1 2 3	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness)								
12 vii 1 2	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions								
12 vii 1 2 3	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness)								
12 vii 1 2 3 4	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis								
12 vii 1 2 3 4 5	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation								
12 vii 1 2 3 4 5 6	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety								
12 vii 1 2 3 4 5 6 7	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression								
12 vii 1 2 3 4 5 6 7 8	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression Psychosis								
12 vii 1 2 3 4 5 6 7 8 9	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression Psychosis Any other psychological disorders Dementia (Memory loss)								
12 vii 1 2 3 4 5 6 7 8 9 10 11	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression Psychosis Any other psychological disorders Dementia (Memory loss) Attention deficit Disorder								
12 vii 1 2 3 4 5 6 7 8 9 9 10	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression Psychosis Any other psychological disorders Dementia (Memory loss)	NO Image: Constraint of the second		NO NO	NO NO	NO	NO	NO NO	
12 vii 1 2 3 4 5 6 7 8 9 10 11	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression Psychosis Any other psychological disorders Dementia (Memory loss) Attention deficit Disorder	NO NO	NO	NO NO	NO NO NO	NO NO NO	NO NO NO	NO NO	
12 vii 1 2 3 4 5 6 7 7 8 9 10 11 11 12	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression Psychosis Any other psychological disorders Dementia (Memory loss) Attention deficit Disorder Any other Other Endocrine (Hormonal) disorders	NO Image: Constraint of the second		NO NO	NO NO	NO	NO	NO NO	
12 vii 1 2 3 4 5 6 7 7 8 9 10 11 11 12	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression Psychosis Any other psychological disorders Dementia (Memory loss) Attention deficit Disorder Any other	NO NO	NO	NO NO	NO NO NO	NO NO NO	NO NO NO	NO NO	
12 vii 2 3 4 5 6 7 8 9 10 11 12 viii	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression Psychosis Any other psychological disorders Dementia (Memory loss) Attention deficit Disorder Any other Other Endocrine (Hormonal) disorders	NO NO	NO	NO NO	NO NO NO	NO NO NO	NO NO NO	NO NO	
12 vii 2 3 4 5 6 7 8 9 10 11 12 12 viii 11	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression Psychosis Any other psychological disorders Dementia (Memory loss) Attention deficit Disorder Any other Other Endocrine (Hormonal) disorders Parathyroid gland disorders	NO NO	NO	NO NO	NO NO NO	NO NO NO	NO NO NO	NO NO	
12 vii 1 2 3 4 5 6 7 8 9 10 11 12 viii 1 2	Inguinal Hernia (Hernia in groin) Irritable bowel syndrome Fatty liver Any other Brain, nerve and Psychiatric (Mental) disorders Recurring or severe headaches / Migraine Febrile Convulsions Vertigo (Recurrent dizziness) Encephalitis Mental Retardation Anxiety Depression Psychosis Any other psychological disorders Dementia (Memory loss) Attention deficit Disorder Any other Other Endocrine (Hormonal) disorders Parathyroid gland disorders	NO NO	NO	NO NO	NO NO NO	NO NO NO	NO NO NO	NO NO	

				1					
1	Gout / Hyperuricemia (high uric acid in blood)								
2	Osteoarthiritis								
3	Shoulder Dislocation								
4	Spondylitis / Spondylosis								
5	Osteoporosis								
6	Prolapse of Inter-vertebral disc (disc prolapse)								
7	Total Knee Replacement								
8	Total Hip Replacement								
9	Any other								
x	Ear, nose, eye and throat disorders	YES NO	YES NO	YES NO	YES				
1	Otitis-media (middle ear infection)				NO	INO	NO		
2	Hearing loss								
3	Nasal Polyp								
4	Sinusitis								
5	Deviated Nasal Septum								
6	Tonsillitis								
7	Pharyngitis (throat infection)								
8	Cataract								
9	Glaucoma								
10	Vocal Cord Nodule								
11	Any other								
xi	Genito-urinary and Gynaecological disorders	YES NO	YES		YES	YES NO	YES	YES	YES
1	Kidney / bladder stones		NO	NO	NO		NO		
2	Recurrent Urinary tract infection								
3	Stricture Urethra								
4	Cytitis/ Infection of urinary bladder								
5	Urinary incontinence								
6	Benign Hypertrophy of Prostate								
7	Hydrocele								
8	Torsion of testes								
9	Phimosis								
10	Breast lump / Cyst / abscess								
11	Ovarian cyst								
12	Endometriosis								
13	Fibroid Uterus								
14	Menstrual disorder / irregular or excessive bleeding								
15	Bartholin's abscess / cyst								
16	Vaginal prolapse								
17	Cervical polyp								
18	Any other								
-		YES	YES	YES	YES	YES	YES	YES	YES
xii	Blood and related disorders	NO	NO	NO	NO	NO	NO	NO	NO
1	Anaemia								
2	Thalassaemia								
3	Sexually transmitted diseases								
4	HIV/AIDS (Acquired Immuno-deficiency syndrome)								
		YES	YES	YES	YES	YES	YES	YES	YES
xiii	Skin disorders	NO	NO	NO	NO	NO	NO	NO	NO
1 2	Psoriasis Eczema								
3	Dermatitis								
4	Urticaria								
5	Vitiligo								
6	Cyst/lump/growth/polyp/tumour								
7	Any other								
xiv	Any other condition / illness / disorder / surgery	YES NO	YES NO	YES	YES NO				

Q3	Has any of the applicants recommended to undergo or has undergone any pathologic or radiologic tests for any illness other than the ones listed above and routine or annual health check-up?		YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Q4	Is any applicant currently not in good health and undergoing any Investigation or treatment or medication for any illness or medical condition (Physical/Mental/Sleep disorders)?	YES	YES NO	YES NO	YES	YES	YES	YES NO	YES NO
Habi	its and Lifestyle questions	Insured '	I 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	YES NO	YES	YES	YES	YES NO	YES	YES	YES
		YES	YES	YES	YES	YES	YES	YES	YES
Α	Smoke	NO	NO	NO	NO	NO	NO	NO	NO
1	Since how long does the applicant smoke								
а	<=20 years								
b	>20 years								
в	Тоbассо	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	How many Pan masala / gutka packets does the applicant has in a day								
а	1-3 packets/day								
b	4-6 packets/day								
с	>6 packets/day								
с	Alcohol	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	How frequently does the applicant consume alcohol								
а	1-3 days/ week								
b	3-6 days/week								
с	Daily								
For	Lifestyle Protection – Critical Illness Add On Cover	Insured ²	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q6	Have any first degree relatives (i.e. parents, brothers, sisters or children) of any of the applicants (who are not themselves applicants for this insurance policy) had cancer, motor neuron disease or any other hereditary disorders	YES	YES	YES	YES	YES	YES	YES	YES

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. Mediclaim, PA, CI, Hospital Cash	Insurer Name	From Date	To Date	Sum Insured		Claim Details	5		mulative us 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
							Claim Number	Claimed Amount	Ailment	%	Amount	exclusions by any insurance company?
Insured 1												YES NO
Insured 2												YES NO
Insured 3												YES NO
Insured 4												YES NO
Insured 5												YES NO
Insured 6												YES NO
Insured 7											YES NO	
Insured 8												YES NO

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></first>	<[[/]	iddle>		<last></last>	Relationship to Proposer	:
Premium Amount	:				in Words			-
Signature	:							
^For Cash Payments of \$	50,000	0 and above Pan N	umber is Mandat	tory				
Payment Option: Chec	que	Demand Dr	aft P	ay Order	Credit C	Card	Debit Card	Cash
For Cheque / DD / Credit Proposal form No.	Card/	Debit Card/ PO/ Ot)	hers (Please sp	ecify)	(Payable	e in favour of "	ManipalCigna Health Insura	ince Company Limited" -
Instrument / Transaction I	Numbe	er :			Instrum	ent/Transactic	on Date: D D M M	
Instrument /Transaction A	moun	t :						
Bank Name		:						
Payment to be collected only fro	om Prop	osers Card/Bank Accou	nt					

XI. BANK ACCOUNT DETAILS*:

Mandatory details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account.

Please select any one of the below options as applicable.

- Bank details as per premium cheque to be used for electronic fund transfer/refund.
- Bank account details as mentioned on the cheque being submitted along with the Proposal Form towards premium payment for insurance Policy should be used by the Company for electronic fund transfer as mode of payment.

Please fill the below table if the premium payment cheque does not have all the details required for electronic fund transfer.

Particulars of Bank Account*:

Account Number:																	
IFSC/MICR Code:																	
Name of the Bank:																	
Account Holder Name:																	

I agree and undertake to intimate in writing to ManipalCigna Health Insurance Co. Ltd about any change in bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

DISCLAIMER: ManipalCigna shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation- failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder.

Aforesaid NEFT transaction shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. ManipalCigna shall be indemnified against any loss/damage/claims caused to ManipalCigna in carrying out your aforesaid NEFT instructions.

Instructions:

- It is important for these electronic payment systems that the Policy Holder's name in the Policy must exactly match with the name in the Bank Account records/details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required.
- The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFS Code, which is applicable for NEFT only. (a number allotted to each participating banks branch) of the branch where the funds need to be transferred.
- Cancelled cheque should be attached along with the NEFT format.
- In case cancelled blank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required.
- NEFT Form needs to be complete in all respect.



Signature of Proposer *:____

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

~

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 a 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.	are true and
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 and that the policy will come into force only after full receipt of the premium chargeable.	e company
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 propos submitted but before communication of the risk acceptance by the company.	al has been
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/ 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 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 a settlement.	on from any
I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting ar settlement and with any Government and/or Regulatory authority, including seeking and/or sharing of my medical data through ABHA	nd/or claims
I hereby consent to and authorize ManipalCigna Health Insurance Company Limited ("Company") and its representatives to collect, use, share a information provided by me, as per the privacy policy of the Company. Company or its representatives are also hereby authorised to contact me (including 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. hereby further d am also aware of the recent regulatory changes (details available at https://irdai.gov.in/web/guest/document-detail?documentl=5625747), wherein 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 hence I hereby request and authorize Insurer to accept my premium along with this proposal to avoid any inconvenience to me,	Insurer has
at my sole cost and consequences	
I hereby agree to the Terms and Conditions of the policy/ies. Signature of Proposer *:	
Date: D M M Y Y Y Place: (A policyholder or prospect, who is a person with disability, may duly authorize a rep give declaration on his/her behalf, if required. For further assistance, please visit new give declaration on his/her behalf, if required. For further assistance, please visit new give declaration on his/her behalf, if required.	
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 understoo and that the Proposer has affixed the thumb impression above after fully understanding the contents thereof.	d to him/her
Signature of Proposer *:	
Date: D M M Y Y Y Place: (A policyholder or prospect, who is a person with disability, may duly authorize a give declaration on his/her behalf, if required. For further assistance, please visit	

XIV. ADVISOR / INTERMEDIARY DECLARATION*:

I,(Full Name)In my capacity as an Insurance Adv employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents or contained in this Proposal Form to the Proposer including statement(s), information and response(s) subm herein or any details sought herein that will form the basis of the Contract of Insurance between the Cor Company for issuance of the Policy. I further confirm that I have explained the product features, terms and of the needs of the customer.	itted by him/her in this Proposal Form to questions contained mpany and the Proposer, if this Proposal is accepted by the
I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Prosubmissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company be forfeited to the company.	payable and further more if there has been a non-disclosure of
License No. / ID (Advisor/Corporate Agent/Broker/Relationship Officer):	
Date: DDMMYYYY Place:	Signature of Agent:

Section 41 of Insurance Act 1938 (Prohibition of rebates):

 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 rupe	es.
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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:	
<b>Note:</b> Neither the submission of a completed proposal for insurance or any payment for any Policy sought oblige the C is and always shall be in the Company's sole and absolute discretion.	ompany to agree to issue a Policy, which decision
If ManipalCigna Health Insurance Company Limited accepts a proposal for insurance, it shall be subject to the board a the Policy terms and conditions of this product and the Company shall have no liability to make any payment if premium	
Company Limited in full and in time, or is not realised.	Is not received by ManipalCigna Health Instrance
Should you choose to pay premium by Cash, you are advised to do so only at the nearest ManipalCigna branch or its a	
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.