

Proposal Form No.: \_\_\_\_\_

**FOR OFFICE USE**

Branch Name*:	Branch Code:
Intermediary Name:	Sourcing Department:
Intermediary Code*: <input type="text"/> Agent Code / Broker Code / CA Code	Business Type: Urban <input type="checkbox"/> Rural <input type="checkbox"/> Social -Yes <input type="checkbox"/> No <input type="checkbox"/>
Ops Tags	Employee DMS Code*: <input type="text"/> Manipal Cigna Employee DMS Code
Partner Vertical Name*: <input type="text"/> Partner Business Vertical Code	Partner Branch ID*: <input type="text"/> Partner Branch Code

**MANIPALCIGNA PROHEALTH GROUP INSURANCE POLICY  
PROPOSAL FORM**

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

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

**I. PROPOSER (CORPORATE DETAILS)** All invoices will be raised to the following address and addressed to the Principle contact person mentioned below

Proposer Name	:	<input type="text"/>	First*	<input type="text"/>	Middle	<input type="text"/>	Last*	<input type="text"/>	
Principle Contact Person's Name	:	<input type="text"/>							
Type of Business	:	<input type="text"/>							
Correspondence (Present) Address*	:	Block No./Flat No.:	<input type="text"/>	Floor No.:	<input type="text"/>	Building Name:	<input type="text"/>		
	:	Street Name:	<input type="text"/>						
	:	Locality:	<input type="text"/>						
	:	Landmark:	<input type="text"/>			City/Village:	<input type="text"/>		
	:	State:	<input type="text"/>			Pin code:	<input type="text"/>		
Permanent Address*	:	Block No./Flat No.:	<input type="text"/>	Floor No.:	<input type="text"/>	Building Name:	<input type="text"/>		
	:	Street Name:	<input type="text"/>						
	:	Locality:	<input type="text"/>						
	:	Landmark:	<input type="text"/>			City/Village:	<input type="text"/>		
	:	State:	<input type="text"/>			Pin code:	<input type="text"/>		
Contact Number	:	Landline:	<input type="text"/>			Mobile Number*:	<input type="text"/>		
Email Address*:	:	<input type="text"/>							
PAN No/ TAN No.^	:	<input type="text"/>							
Aadhaar No.^	:	<input type="text"/>							
Customer Goods & Service Tax Identification Number (if any):									
Period of Insurance	:	From:	<input type="text"/> D <input type="text"/> D	<input type="text"/> M <input type="text"/> M	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	To:	<input type="text"/> D <input type="text"/> D	<input type="text"/> M <input type="text"/> M	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y
Please state whether all eligible employees/families, members/families of the Group/Association/Institution/Corporate Body are proposed for Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>									
Please state the Total Number of Employees/ Members to be covered (including families / dependents wherever covered): _____									
Policy Type	:	<input type="checkbox"/> Individual	<input type="checkbox"/> Family Floater	<input type="checkbox"/> Both					

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

**II. INSURED DETAILS**

Is the Address of insured different from that of the Proposer?	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes please provide:	<input type="text"/>	

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

Details	Insured 1	Insured 2	Insured 3	Insured
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Unique identification No./ Employee No./ Membership No.				
Name of Insured member				
Relationship of the family members with the Employee/ Member				
Designation/ Category/ position				
Date of Enrollment/ Joining				
Date of Birth				
Gender				
Pre-existing Diseases				
Email ID				
Mobile No.				
Permanent Address* (AS per the KYC proof submitted)	Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) / State*/ Pin Code*	Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) / State*/ Pin Code*	Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) / State*/ Pin Code*	Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) / State*/ Pin Code*
Correspondence Address*	<input type="checkbox"/> Same as above Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) / State*/ Pin Code*	<input type="checkbox"/> Same as above Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) / State*/ Pin Code*	<input type="checkbox"/> Same as above Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) / State*/ Pin Code*	<input type="checkbox"/> Same as above Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) / State*/ Pin Code*
Occupation*:	<input type="checkbox"/> Government Service <input type="checkbox"/> Private Sector <input type="checkbox"/> Self Employed <input type="checkbox"/> Others (please Specify _____)	<input type="checkbox"/> Government Service <input type="checkbox"/> Private Sector <input type="checkbox"/> Self Employed <input type="checkbox"/> Others (please Specify _____)	<input type="checkbox"/> Government Service <input type="checkbox"/> Private Sector <input type="checkbox"/> Self Employed <input type="checkbox"/> Others (please Specify _____)	<input type="checkbox"/> Government Service <input type="checkbox"/> Private Sector <input type="checkbox"/> Self Employed <input type="checkbox"/> Others (please Specify _____)
Do you come under the below-mentioned social sector classification? Yes <input type="checkbox"/> No <input type="checkbox"/>				
<p>("Social Sector" includes Unorganised Sector, Informal Sector, Economically Vulnerable or Backward Classes and Other Categories of Persons, residing in both rural and urban areas.</p> <p>(a) "Unorganised sector" means an enterprise owned by individuals or self-employed workers and engaged in the production or sale of goods or providing service of any kind whatsoever, and where the enterprise employs workers; the number of such workers is less than ten.</p> <p>(b) "Informal Sector" includes small scale, self-employed workers typically at a low level of organisation and technology, with the primary objective of generating employment and income, with heterogeneous activities like retail trade, transport, repair and maintenance, construction, personal and domestic services and manufacturing, with the work mostly labour intensive, having often unwritten and informal employer-employee relationship.</p> <p>(c) "Economically Vulnerable or Backward Classes" means persons who live below the poverty line.</p> <p>(d) "Other Categories of Persons" includes persons with disability as defined in Rights of Persons with Disabilities Act, 2016 and who may not be gainfully employed; and also includes guardians who need insurance to protect spastic persons or persons with disability.)</p>				
Social Sector Card/ Document: (Please submit a copy of selected proof)	<input type="checkbox"/> BPL Card <input type="checkbox"/> MNREGA Card <input type="checkbox"/> eShram Card <input type="checkbox"/> PM Vishwakarma Yojana <input type="checkbox"/> Jan Dhan Account Holder <input type="checkbox"/> DBT (Direct Benefit Transfer) Beneficiaries <input type="checkbox"/> PM Kisan Sanman Yojana <input type="checkbox"/> PM Awas Yojana <input type="checkbox"/> Pradhan Mantri Jan Arogya Yojna <input type="checkbox"/> Pradhan Mantri Mudra Yojna <input type="checkbox"/> Any other document issued by State/Central Government Please specify _____  Document Number*: _____ (Please specify the selected document number)	<input type="checkbox"/> BPL Card <input type="checkbox"/> MNREGA Card <input type="checkbox"/> eShram Card <input type="checkbox"/> PM Vishwakarma Yojana <input type="checkbox"/> Jan Dhan Account Holder <input type="checkbox"/> DBT (Direct Benefit Transfer) Beneficiaries <input type="checkbox"/> PM Kisan Sanman Yojana <input type="checkbox"/> PM Awas Yojana <input type="checkbox"/> Pradhan Mantri Jan Arogya Yojna <input type="checkbox"/> Pradhan Mantri Mudra Yojna <input type="checkbox"/> Any other document issued by State/Central Government Please specify _____  Document Number*: _____ (Please specify the selected document number)	<input type="checkbox"/> BPL Card <input type="checkbox"/> MNREGA Card <input type="checkbox"/> eShram Card <input type="checkbox"/> PM Vishwakarma Yojana <input type="checkbox"/> Jan Dhan Account Holder <input type="checkbox"/> DBT (Direct Benefit Transfer) Beneficiaries <input type="checkbox"/> PM Kisan Sanman Yojana <input type="checkbox"/> PM Awas Yojana <input type="checkbox"/> Pradhan Mantri Jan Arogya Yojna <input type="checkbox"/> Pradhan Mantri Mudra Yojna <input type="checkbox"/> Any other document issued by State/Central Government Please specify _____  Document Number*: _____ (Please specify the selected document number)	<input type="checkbox"/> BPL Card <input type="checkbox"/> MNREGA Card <input type="checkbox"/> eShram Card <input type="checkbox"/> PM Vishwakarma Yojana <input type="checkbox"/> Jan Dhan Account Holder <input type="checkbox"/> DBT (Direct Benefit Transfer) Beneficiaries <input type="checkbox"/> PM Kisan Sanman Yojana <input type="checkbox"/> PM Awas Yojana <input type="checkbox"/> Pradhan Mantri Jan Arogya Yojna <input type="checkbox"/> Pradhan Mantri Mudra Yojna <input type="checkbox"/> Any other document issued by State/Central Government Please specify _____  Document Number*: _____ (Please specify the selected document number)
ABHA #				
Sum Insured				
Optional Cover				
Optional Cover Sub Option				
Optional Cover Sum Insured/Limit				

### NOMINEE DETAILS\*:

Is the Nominee same as Proposer (if provided above)? ☐ Yes ☐ No. If No, please provide Nominee details.

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

In the event of death of the Proposer, any payment due under the Policy shall become payable to the nominee, as per the 'Nomination' clause defined by the IRDAI and the receipt of the proceeds by such nominee would be sufficient discharge to the Company. For all other persons covered under the Policy, the Proposer will be the nominee.

### III. PLAN DETAILS

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

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

Policy Tenure	<input type="checkbox"/> 1Year <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/> 4 Years <input type="checkbox"/> 5 Years
Base Sum Insured	₹ _____
Base Cover	Option
In-patient Hospitalization Expenses Cover	(Per Day Room rent expenses capped at 1% of Sum Insured and 2% of Sum Insured for ICU)
Day Care Treatment Cover	<input type="checkbox"/> No Day Care <input type="checkbox"/> 10% of SI <input type="checkbox"/> 25% of SI <input type="checkbox"/> 50% of SI <input type="checkbox"/> 100% of SI
Pre-Hospitalization/ Post Hospitalization Medical Expenses Cover	Pre-Hospitalization _____ Days Post-Hospitalization _____ Days 0-180 Days
Road Ambulance Cover	Sum insured: ₹ _____ ₹250 to ₹ 20,000
Domiciliary Treatment	
Donor Expenses	

Sr. No.	Optional Cover	Sum Insured	Sub Limit	Sub options
1	<input type="checkbox"/> Disease Category Sub Limit	NA	₹ _____ The category limit options: From ₹ 1 Lac to ₹ 10 Lacs	NA
2	<input type="checkbox"/> Maternity Expenses Cover		₹ _____ Sub-Limit Options available: From ₹ 10,000 to ₹ 5 Lacs	<input type="checkbox"/> Normal Delivery ____% <input type="checkbox"/> Routine or elective C-section delivery ____% <input type="checkbox"/> Complicated Pregnancy ____% <input type="checkbox"/> Pre & Post Natal Expense ____% Limit for each option: From 1% - 100% of Maternity Sum Insured <input type="checkbox"/> ₹ Cover for Surrogacy pregnancy
2 a	<input type="checkbox"/> New Born Medical Expenses Cover (The option is available with Maternity Expenses cover)		₹ _____ Sub Limit Options available: From ₹ 10,000 to ₹ 5 Lacs	Options available: <input type="checkbox"/> To be part of maternity Sub Limit <input type="checkbox"/> To be in addition to Sub Limit for maternity expenses cover

3	<input type="checkbox"/> Out Patient Treatment Cover	₹ _____ Sum Insured Options available: From ₹ 1,000 to ₹ 5 Lacs		Any one or combination of the following can be opted under the cover: <input type="checkbox"/> Consultation <input type="checkbox"/> Diagnostics <input type="checkbox"/> Pharmacy <input type="checkbox"/> Medical Aids <input type="checkbox"/> AYUSH <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Over the Counter (OTC) Medicines Cover limit Options: <input type="checkbox"/> Up to opted Sum Insured <input type="checkbox"/> Up to opted Sum Insured with _____ x% co-pay, where x can be 1-50%
4	<input type="checkbox"/> Accumulate Cover	₹ _____ Sum Insured Options available: ₹ 5,000 to Up to Sum Insured	NA	Any one or combination of the following can be opted under the cover: <input type="checkbox"/> Consultation <input type="checkbox"/> Diagnostics <input type="checkbox"/> Pharmacy <input type="checkbox"/> Medical Aids <input type="checkbox"/> AYUSH <input type="checkbox"/> Reasonable and Customary Charges towards payment of the Deductible/Co-Payment/non- payable of an In-patient Hospitalization Expenses claim or day care treatment claim Option to opt for Cumulative Bonus <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, choose the Bonus Percentage _____% (Choose any number between 1% - 100%)
5	<input type="checkbox"/> In-patient hospitalization – Percentage limit on room rent/ Amount limit on room rent/ Limit on room type (Category)		<b>Per Day Room Rent as a percentage limit of Sum Insured:</b> _____% 2% - 10% In case of ICU the limit will be two times Room rent OR <b>Per Day Room Rent amount limit:</b> ₹ _____ ₹ 500 to ₹ 10,000 In case of ICU the limit will be two times Room rent OR	
			<b>Room type limit:</b> <input type="checkbox"/> Ward <input type="checkbox"/> Up to Shared Room <input type="checkbox"/> Up to Single Private Room <input type="checkbox"/> Up to Deluxe Room <input type="checkbox"/> Up to any room other than Suite <input type="checkbox"/> No room type cap <b>ICU Limits with respect to room rent:</b> <input type="checkbox"/> _____ 'x' times the room rent <input type="checkbox"/> No Cap (Where 'x' can be any number or fraction max up to 10)	
6	<input type="checkbox"/> Sub limit on Treatment/ Illness/ Disease/ Surgery/ Medical Condition	NA	<input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3	
7	<input type="checkbox"/> Voluntary Co-pay for In-patient Hospitalization	NA	NA	Voluntary Co-pay options: (Percentage of admissible claim amount) _____% 5% - 50%
8	<input type="checkbox"/> Annual Aggregate Deductible	NA	NA	Options available: ₹ 1,000 to ₹ 10 Lacs ₹ _____

9	<input type="checkbox"/> <b>Per Claim Deductible</b>	NA	NA	Options available: ₹ 500 to ₹ 10 Lacs ₹ _____
10	<input type="checkbox"/> <b>Corporate Deductible at a Group level</b>	NA	NA	Corporate deductible option: ₹ 2 Lacs to ₹ 100 Lacs ₹ _____
11	<input type="checkbox"/> <b>Maximum limit on Out of Pocket expenses</b> (Available only with the Voluntary Co-pay option)	NA	NA	Maximum limit on out of pocket expenses option: ₹ 5,000 to ₹ 10 Lacs ₹ _____
12	<input type="checkbox"/> <b>Directed Plan</b>	NA	NA	Directed plan options available: <input type="checkbox"/> x% co pay on admissible claim amount within network <input type="checkbox"/> x% co pay on admissible claim amount outside network <input type="checkbox"/> x% co pay on admissible claim amount for non – Personal accident/Critical Illness and no co-pay for Personal accident/Critical Illness within network <input type="checkbox"/> x% co pay on admissible claim amount for non - Personal accident/Critical Illness and no co-pay of Personal accident/Critical Illness out of network <input type="checkbox"/> Only directed network x = _____ % (Choose between 5% to 50%)
13	<input type="checkbox"/> <b>Reimbursement only cover</b>	NA	NA	NA
14 a	<input type="checkbox"/> <b>Hospital Daily Cash Benefit Cover</b>	₹ _____ Hospital Daily cash benefit option: ₹ 200 to ₹ 10,000 per day of hospitalization	NA	Maximum limit on number of days per Policy Year: _____ days (Choose between 30 – 90 ) Deductible options <input type="checkbox"/> 1 day <input type="checkbox"/> 2 days Period of hospitalisation as per Benefit Table: <input type="checkbox"/> 24 Hours <input type="checkbox"/> 48 Hours <input type="checkbox"/> 72 Hours
14 b	<input type="checkbox"/> <b>Accidental Hospital Daily Cash Benefit Cover</b>	₹ _____ Accidental Hospital Daily Cash Benefit Options available: ₹ 200 to ₹ 20,000 per day of hospitalization	NA	Maximum limit on number of days per Policy Year: _____ days (Choose between 30 - 90 ) Deductible options <input type="checkbox"/> 1 day <input type="checkbox"/> 2 days Period of hospitalisation as per Benefit Table: <input type="checkbox"/> 24 Hours <input type="checkbox"/> 48 Hours <input type="checkbox"/> 72 Hours
14 c	<input type="checkbox"/> <b>Worldwide Hospital Daily Cash Benefit Cover</b>	₹ _____ Worldwide Hospital Daily Cash Benefit Options available: ₹ 200 to ₹ 30,000 per day of hospitalization	NA	Maximum limit on number of days per Policy Year: _____ days (Choose between 30 - 90 ) Deductible options <input type="checkbox"/> 1 day <input type="checkbox"/> 2 days Period of hospitalisation as per Benefit Table: <input type="checkbox"/> 24 Hours <input type="checkbox"/> 48 Hours <input type="checkbox"/> 72 Hours
14 d	<input type="checkbox"/> <b>Convalescence Benefit Cover</b>	₹ _____ Sum Insured options available: ₹ 2,000 - ₹ 1 Lac	NA	
14 e	<input type="checkbox"/> <b>Companion Benefit Cover</b>	₹ _____ Sum Insured options available: ₹ 200 to ₹ 10,000 per day of hospitalization	NA	
14 f	<input type="checkbox"/> <b>ICU Daily Cash Benefit Cover</b>	₹ _____ ICU Daily Cash Benefit Options available: ₹ 200 to ₹ 10,000 per day of hospitalization	NA	Maximum limit on number of days per Policy Year: _____ days (Choose between 30 – 90 ) Deductible options <input type="checkbox"/> 1 day <input type="checkbox"/> 2 days Period of hospitalisation as per Benefit Table: <input type="checkbox"/> 24 Hours <input type="checkbox"/> 48 Hours <input type="checkbox"/> 72 Hours
14 g	<input type="checkbox"/> <b>Chemotherapy and Radiotherapy Benefit</b>	₹ _____ Sum Insured options available: ₹ 1,000 to ₹ 50,000 per sitting	NA	Maximum limit on number of sittings: _____ From 5 sittings to Unlimited sittings per year
15 a	<input type="checkbox"/> <b>Critical Illness Benefit Cover</b>	₹ _____ Sum insured From ₹ 10,000 to ₹ 1 Crore	NA	NA
15 b	<input type="checkbox"/> <b>Critical Illness Indemnity Cover</b>	₹ _____ Sum insured From ₹ 5,000 to ₹ 1 Crore	NA	NA

15 c	<input type="checkbox"/> Expert Opinion On Critical Illness	NA	NA	Options available: <input type="checkbox"/> Domestic Expert Opinion <input type="checkbox"/> Worldwide Expert Opinion
15 d	<input type="checkbox"/> Loss of Pay Cover	Sum insured ₹ _____ From ₹ 1,000 to ₹ 1 Lac subject to a maximum of 50 weeks per Policy Year		Any one or combination of the following can be opted under the cover: <input type="checkbox"/> Specified Critical Illness <input type="checkbox"/> Injury due to an accident leading to Disablement <input type="checkbox"/> Any illness where hospitalization is above _____ Days, (Choose between 5 days to 15 days)
16 a	<input type="checkbox"/> Accidental Death Benefit Cover	₹ _____ Sum insured From ₹ 50,000 to ₹ 1 Crore	NA	NA
16 b	<input type="checkbox"/> Permanent Total Disablement Benefit Cover	₹ _____ Sum insured From ₹ 50,000 to ₹ 1 Crore	NA	NA
16 c	<input type="checkbox"/> Permanent Partial Disablement Benefit Cover	₹ _____ Sum insured From ₹ 50,000 to ₹ 1 Crore	NA	NA
17	<input type="checkbox"/> Dental Expenses Cover	₹ _____ Sum Insured options available: From ₹ 1,000 to ₹ 2 Lacs	NA	Any one or combination of the following can be opted under the cover: <input type="checkbox"/> Class 1 (Investigative & Preventative Treatment) <input type="checkbox"/> Class 2 (Basic Restorative, Periodontal Treatment) <input type="checkbox"/> Class 3 (Major Restorative & Orthodontic Treatment) Limit Options available: <input type="checkbox"/> Up to the Sum Insured <input type="checkbox"/> Up to the Sum Insured with x% co-pay x = _____ % (Choose between 10% to 20%)
18	<input type="checkbox"/> Vision Expenses Cover	₹ _____ Sum Insured Options available: From ₹ 1,000 to ₹ 1 Lac	NA	Limit Options available: <input type="checkbox"/> Up to the Sum Insured <input type="checkbox"/> Up to the Sum Insured with x% co-pay x = _____ % (Choose between 10% to 20%)
19	<input type="checkbox"/> Refractive Error Correction beyond +/-5 Expenses Cover		₹ _____ Sub Limit Options available: From ₹ 1,000 to ₹ 1 Lac	
20	<input type="checkbox"/> OPD Physiotherapy Charges Cover	₹ _____ Sum Insured Options available: From ₹ 1,000 to ₹ 50,000	NA	Limit Options available: <input type="checkbox"/> Up to the Sum Insured <input type="checkbox"/> Up to the Sum Insured with x% co-pay x = _____ % (Choose between 10% to 20%)
21	<input type="checkbox"/> Routine Immunisations Cover	NA	₹ _____ Sub-Limit Options available: From ₹ 1,000 to ₹ 25,000	NA
22	<input type="checkbox"/> Home Nursing Charges Cover	NA	₹ _____ Sub Limit Options available: From ₹ 50,000 to ₹ 1 Lac	
23	<input type="checkbox"/> Health Check Up Benefit	NA	NA	Frequency of Health Check-up Options available: <input type="checkbox"/> Every year <input type="checkbox"/> Every Year after 1st Renewal <input type="checkbox"/> Once in 2 Years <input type="checkbox"/> Once in 3 Years <input type="checkbox"/> Once in 4 Years Dependency on claims to be selected: <input type="checkbox"/> Available only subsequent to claim free year <input type="checkbox"/> Available irrespective of claim in previous year For a floater policy the cover can be further limited by selecting anyone of options listed below <input type="checkbox"/> To Primary Member in Floater policy <input type="checkbox"/> To each member
24	<input type="checkbox"/> Compassionate Cover for family member in case of Emergency or Accident	₹ _____ Sum Insured Options available: From ₹ 1,000 to ₹ 1 Lac	NA	NA

25	<input type="checkbox"/> Air Ambulance Cover	NA	₹ _____ Sub Limit Options available: From ₹ 50,000 to ₹ 5 Lacs	NA
26	<input type="checkbox"/> Emergency Evacuation Cover	NA	₹ _____ Sub Limit Options available: From ₹ 50,000 to ₹ 5 Lacs	NA
27	<input type="checkbox"/> Medical Equipment Cover	NA	₹ _____ Sub Limit Options available: From ₹ 5,000 to ₹ 50,000	NA
28	<input type="checkbox"/> Bariatric Surgery Cover	NA	₹ _____ Sub Limit Options available: From ₹ 5,000 to ₹ 5 Lacs	NA
29	<input type="checkbox"/> Adventure Sports Cover	NA	₹ _____ Sub Limit Options available: From ₹ 25,000 to ₹ 1 Crore	
30	<input type="checkbox"/> Birth Control Procedure Cover	NA	₹ _____ Sub Limit Options available: From ₹ 5,000 to ₹ 25,000	NA
31	<input type="checkbox"/> Infertility Treatment Cover	NA	₹ _____ Sub Limit Options available: ₹ 5,000 to ₹ 5 Lacs	Options available: <input type="checkbox"/> To be part of maternity Sub Limit <input type="checkbox"/> To be in addition to Sub Limit for maternity expenses cover
32	<input type="checkbox"/> In-patient hospitalization Cover for Ayush Treatment	NA	₹ _____ Sub Limit Options available: From ₹ 5,000 to Up to Sum Insured	NA
33	<input type="checkbox"/> Enhanced Hospitalization Cover	Sum insured options available: <input type="checkbox"/> x% of the Base Sum Insured x= _____% (Choose between 50% to 300%) Maximum limit of ₹ _____ (Choose any limit up to Sum Insured)		Choose incident to be covered: <input type="checkbox"/> Accident <input type="checkbox"/> Critical Illness/es (Any one or more Critical Illness/es can be selected from the list of 36 Cls.)
34	<input type="checkbox"/> Worldwide Emergency Cover	NA	Covered up to Base Sum Insured	Choose any one option: <input type="checkbox"/> Emergency treatments for all illness including Pre-existing Diseases <input type="checkbox"/> Emergency treatments for all illnesses excluding Pre-existing Diseases
35	<input type="checkbox"/> Restoration of Sum Insured	NA	NA	Choose any one of the categories: <input type="checkbox"/> Category 1: Upto base SI for unrelated illness <input type="checkbox"/> Category 2: Upto base SI for any illness Options available in a Policy Year: <input type="checkbox"/> Once <input type="checkbox"/> 2 times <input type="checkbox"/> 4 times <input type="checkbox"/> 9 times <input type="checkbox"/> Unlimited times
36	<input type="checkbox"/> Cumulative bonus	NA		Options available: x% of Base Sum Insured per year Maximum up to 100% of the Base Sum Insured x = _____% (x can be any number from 1 to 100) <input type="checkbox"/> Non Reducing CB irrespective of claim
37	<input type="checkbox"/> Corporate Buffer (At group Level)	₹ _____ Sum Insured Options available: From ₹ 5,000 to ₹ 10 Crores	NA	The cover can be limited by selecting any one option: <input type="checkbox"/> Per person limit <input type="checkbox"/> Per policy floater limit (as a % of sum insured per policy year)
38	<input type="checkbox"/> Corporate Buffer for Critical Illness only (At group Level)	₹ _____ Sum Insured Options available: From ₹ 5,000 to ₹ 10 Crores	NA	The cover can be limited by selecting any one option: <input type="checkbox"/> Per person limit <input type="checkbox"/> Per policy floater limit (as a % of sum insured per policy year)

39	<input type="checkbox"/> Healthy Living Reward Program	NA	NA	<p>Any one or a combination of following programs can be offered under this program:</p> <input type="checkbox"/> Enrollment into Wellness Program <input type="checkbox"/> Health Risk Assessment (HRA) <input type="checkbox"/> Targeted Risk Assessment (TRA) <input type="checkbox"/> Online Lifestyle Management Program (LMP) <input type="checkbox"/> Chronic Condition Management Programs <input type="checkbox"/> Participating in ManipalCigna Sponsored Programs and Worksite or Online/Offline Health Initiatives <input type="checkbox"/> Health Check Up Healthy Reward Points may be awarded on enrollment in the policy or completing various programs
40	<input type="checkbox"/> Condition Management Reward Program	NA	NA	
41	<input type="checkbox"/> Wellness Services Program	NA	NA	<p>Wellness Services:</p> <input type="checkbox"/> Track your Health <input type="checkbox"/> Medical Concierge services <input type="checkbox"/> Health check up <input type="checkbox"/> Medical Practitioner's consultations <input type="checkbox"/> Health tips or newsletters <input type="checkbox"/> Well-baby Care <input type="checkbox"/> Well-Mother Care
42	<input type="checkbox"/> Sub-limits Cover	<< Sub-limits as opted will be displayed >>		

Sr. No.	Waiting Period Clause	Waiting Period	Options
1	<input type="checkbox"/> Pre-existing Diseases	3 Years since date of inception of the cover	_____ Months Choose any number of months from 0 - 36 months
2	<input type="checkbox"/> 30- day Waiting Period	30 Days since date of inception of the cover	_____ Days Choose any number of days from 0 - 90 days
3	<input type="checkbox"/> Specified disease/procedure Waiting period	2 Years since date of inception of the cover	_____ Months Choose any number of months from 0 - 36 months
4	<input type="checkbox"/> Maternity waiting period	3 Years since date of inception of the cover	_____ Months Choose any number of months from 0 - 36 months
5	<input type="checkbox"/> Critical Illness Waiting period	90 days since date of inception of the cover	_____ Days Choose any number of days from 0 - 90 days
6	<input type="checkbox"/> Survival Period for Critical Illness	30 Days since date of first diagnosis of the covered Critical Illness	_____ Days Choose any number of days from 0 - 30 days

#### IV. DETAILS OF PREVIOUS INSURER(S) (if renewal)

Are your employees/ members at present insured?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'Yes' Please provide the details insurer, type of policy with coverage & sum insured-(attach additional sheet if required)		
Name of Insurer:		
Policy Number :		
Expiring Terms of cover:	(PA or CI or Health)	
Name of TPA		
Period of Insurance:		
Premium paid:		
Claim details:	(Please attach separate sheet providing complete details of claims with individual claim records)	
Incurred Claims Ratio:		
<i>Note: Ensure that the information in this form material for assumption of risk is accurate and complete as inaccuracy or non-disclosure of the requested information or other material facts could preclude recovery of any claim under the policy</i>		

#### V. CURRENT INSURANCE DETAILS

Insured	Policy No.	Insurer Name	From Date	To Date	Sum Insured	Cumulative Bonus Earned	
						%	Amount
Insured 1							
Insured 2							
Insured 3							
Insured 4							
Insured 5							

**VI. PREMIUM PAYMENT DETAILS** (Please provide the details of premium payment)

Premium Amount (INR): _____	Payment Option (pl. tick (√)):
	<input type="checkbox"/> Cheque <input type="checkbox"/> DD <input type="checkbox"/> Fund Transfer
Amount In words: _____	
Payment Frequency : <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Half Yearly <input type="checkbox"/> Single <input type="checkbox"/> Annually	
<i>For Cheque / DD (Payable in favour of "ManipalCigna Health Insurance Company Limited" )</i>	
Instrument no.: _____	Instrument Date: _____   Instrument Amount: _____
Bank Name: _____	
Name of Premium Payer: _____	

**VII. 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/We will maintain details of all the individual members covered, which shall also be made available to the insurance company as and when required.

I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.

I/We further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company

I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at 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.

☐ I hereby provide my/our explicit and informed consent to Company or its representatives to contact me and members insured under the Policy (including overriding my registration on NCPR/NDNC and/or under any extant TRAI regulations) and / or notify about the services being rendered by the Company.

☐ I/We, hereby agree that the PAN details and other information provided by me/us in the proposal form maybe used by the Company or its authorized representatives to access/download/verify/register/ update my/our KYC documents on/from the CERSAI\* CKYC portal for processing this application and for any servicing, claims and other requests. (\*Central Registry of Securitisation and Asset Reconstruction and security Interest of India.) I hereby consent that I may receive information from Central KYC Registry through sms / email on the above registered number/email address related to this proposal / policy.

Also, I hereby provide my/our explicit and informed consent to and authorize ManipalCigna Health Insurance Company Limited ("Company") and its representatives to collect, use, share and disclose information including personal information and claim information of all members insured under the Policy ("Personal Information") provided by me, as per the privacy policy of the Company, for the sole purpose of servicing the policy. I also declare that I have the necessary authorization from all members insured under the Policy to collect/ process/ authorize sharing of all Personal Information with the insurance company, insurance intermediaries and associated service providers for sole purpose of insurance policy servicing.

I hereby agree to the Terms and Conditions of the policy/ies.

Date: \_\_\_\_\_

Signature of Proposer: \_\_\_\_\_

Place: \_\_\_\_\_

**VIII. ADVISOR/INTERMEDIARY DECLARATION:**

In my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein that will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I further confirm that I have explained the product features, terms and conditions to the prospect and the product opted is suitable to the needs of the customer.

I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

License No. / ID (Advisor/Corporate Agent/Broker/Relationship Officer): \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Corporate Agent: \_\_\_\_\_

Place: \_\_\_\_\_

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

- 1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of 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 prospectuses 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.

**Insurance is a subject matter of solicitation**

## 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:

[illegible][illegible]

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

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

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

**Instructions:**

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

Date:   /   -    

**Signature of Proposer/Authorized Representative\*:**

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

Annexure - A  
KYC of Beneficial owners

Photograph of Insured 1	Photograph of Insured 2	Photograph of Insured 3	Photograph of Insured 4
Photograph of Insured 5	Photograph of Insured 6	Photograph of Insured 7	Photograph of Insured 8

Title*	:	Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>	Gender*:	Male <input type="checkbox"/> Female <input type="checkbox"/> Others <input type="checkbox"/>	Tick if Employer is the Payor: <input type="checkbox"/>																																
Date of Birth*	:	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	Marital Status*:	Married <input type="checkbox"/> Single <input type="checkbox"/> Others <input type="checkbox"/>																									
D	D	M	M	Y	Y	Y	Y																														
Beneficial Owner Name*: (as in bank account)	:	<table><tr><td></td><td></td><td>F</td><td>I</td><td>R</td><td>S</td><td>T</td><td>*</td><td></td><td></td><td></td><td></td><td>M</td><td>I</td><td>D</td><td>D</td><td>L</td><td>E</td><td></td><td></td><td></td><td></td><td>L</td><td>A</td><td>S</td><td>T</td><td>*</td><td></td><td></td><td></td><td></td></tr></table>							F	I	R	S	T	*					M	I	D	D	L	E					L	A	S	T	*				
		F	I	R	S	T	*					M	I	D	D	L	E					L	A	S	T	*											
Permanent Address* (As per the KYC proof submitted)	:	Address 1: <input type="text"/>					Address 2: <input type="text"/>					Landmark: <input type="text"/>																									
		City*: <input type="text"/>					Town (District): <input type="text"/>					State*: <input type="text"/>										Pin Code*: <input type="text"/>															
Present Address* (As per the KYC proof submitted)	:	Address 1: <input type="text"/>					Address 2: <input type="text"/>					Landmark: <input type="text"/>																									
		City*: <input type="text"/>					Town (District): <input type="text"/>					State*: <input type="text"/>										Pin Code*: <input type="text"/>															
Email Address*	:	Address 1: <input type="text"/>					Address 2: <input type="text"/>																														
Telephone Number(s)	:	Mobile*: <input type="text"/>					Residence (Optional): <input type="text"/>					Office(Optional): <input type="text"/>																									
Customer Goods & Service Tax Identification Number (if any):	:	<input type="text"/>																																			
Residential Status*	:	Indian <input type="checkbox"/> NRI <input type="checkbox"/> If NRI, Please mention country <input type="text"/> Other (Please specify) <input type="text"/>																																			
PAN Card Number*	:	<input type="text"/>																																			
Form 60* (only in case where PAN number is not available):	:	Yes <input type="checkbox"/> No <input type="checkbox"/>																																			
Identity Document Type	:	Aadhaar Card <input type="checkbox"/> Driving License <input type="checkbox"/> Passport <input type="checkbox"/> Voter's ID card <input type="checkbox"/> Others <input type="checkbox"/>																																			
VID Number (Please mention only last four digits of your Aadhaar or VID)	:	<input type="text"/>										Document Expiry date: <table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>															D	D	M	M	Y	Y	Y	Y			
D	D	M	M	Y	Y	Y	Y																														
CKYC number	:	<input type="text"/>										EIA number: <input type="text"/>																									
PEP or relative of PEP	:	<input type="text"/>																																			