

Proposal Form No.: _____

FOR OFFICE USE

| | | | |
|--------------------|---------------------------------|--------------------------------|------------------------------------|
| Branch Name*: | Branch Code: | Business Type: | Urban/ Social/ Rural |
| Intermediary Name: | Sourcing Department: | Intermediary Code*: | Agent Code / Broker Code / CA Code |
| Ops Tags | Employee DMS Code*: | Partner Vertical Name*: | Partner Branch ID*: |
| | Manipal Cigna Employee DMS Code | Partner Business Vertical Code | 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 : _____
 First* Middle Last*

Principle Contact Person's Name : _____

Type of Business : _____

Correspondence (Present) Address* : Block No./Flat No.: _____ Floor No.: _____ Building Name: _____
 Street Name: _____
 Locality: _____
 Landmark: _____ City/Village: _____
 State: _____ Pin code: _____

Permanent Address* : Block No./Flat No.: _____ Floor No.: _____ Building Name: _____
 Street Name: _____
 Locality: _____
 Landmark: _____ City/Village: _____
 State: _____ Pin code: _____

Contact Number : Landline: _____ Mobile Number*: _____

Email Address*: _____

PAN No/ TAN No.^ : _____ (Mandatory for premium of `50,000 and above accepted in Cash/DD or `100,000 and above by Cheque/Credit/Debit Card)

Aadhaar No.^ : _____

Customer Goods & Service Tax Identification Number (if any): _____

Period of Insurance : From: DD MM YYYY To: DD MM YYYY

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

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

Policy Type : Individual Family Floater 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="checkbox"/> Yes <input type="checkbox"/> No |
| If Yes please provide: | |

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

| | | | | |
|--|--|--|--|--|
| 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. | | | | |
| ABHA # | | | | |
| Sum Insured | | | | |
| Optional Cover | | | | |
| Optional Cover Sub Option | | | | |
| Optional Cover Sum Insured/Limit | | | | |

Nominee Details*:

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

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

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

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) | | Per Day Room Rent as a percentage limit of Sum Insured: ____% 2% - 10% In case of ICU the limit will be two times Room rent OR Per Day Room Rent amount limit: ₹ _____ ₹ 500 to ₹ 10,000 In case of ICU the limit will be two times Room rent OR | |

| | | | | |
|------|---|--|---|---|
| | | | Room type limit: <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 ICU Limits with respect to room rent: <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"/> Per Claim Deductible | NA | NA | Options available: ₹ 500 to ₹ 10 Lacs ₹ _____ |
| 10 | <input type="checkbox"/> Corporate Deductible at a Group level | NA | NA | Corporate deductible option: ₹ 2 Lacs to ₹ 100 Lacs ₹ _____ |
| 11 | <input type="checkbox"/> Maximum limit on Out of Pocket expenses (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"/> Directed Plan | 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"/> Reimbursement only cover | NA | NA | NA |
| 14 a | <input type="checkbox"/> Hospital Daily Cash Benefit Cover | ₹ _____ 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"/> Accidental Hospital Daily Cash Benefit Cover | ₹ _____ 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"/> Worldwide Hospital Daily Cash Benefit Cover | ₹ _____ 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"/> Convalescence Benefit Cover | ₹ _____ Sum Insured options available: ₹ 2,000 - ₹ 1 Lac | NA | |
| 14 e | <input type="checkbox"/> Companion Benefit Cover | ₹ _____ Sum Insured options available: ₹ 200 to ₹ 10,000 per day of hospitalization | NA | |
| 14 f | <input type="checkbox"/> ICU Daily Cash Benefit Cover | ₹ _____ 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"/> Chemotherapy and Radiotherapy Benefit | ₹ _____ 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"/> Critical Illness Benefit Cover | ₹ _____ Sum insured From ₹ 10,000 to ₹ 1 Crore | NA | NA |
| 15 b | <input type="checkbox"/> Critical Illness Indemnity Cover | ₹ _____ 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 | 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 | <i>Any one or a combination of following programs can be offered under this program:</i> <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 | <u>Wellness Services:</u> <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 | 36 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 – 24 months |
| 4 | <input type="checkbox"/> Maternity waiting period | 4 Years since date of inception of the cover | _____ Months Choose any number of months from 0 – 48 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 consent to and authorize Company and its representatives to collect, use, share and disclose information provided by me, as per the privacy policy of the Company. Company or its representatives are also hereby authorized to contact me (including overriding my registry on NCPR/NDNC and/or under any extant TRAI regulations) and / or notify about the services being rendered by the Company".

Further, I hereby provide my consent and authorize Company and its representatives to collect the premium upfront at proposal stage. I hereby further declare that I am also aware of the recent regulatory changes (details available at <https://irdai.gov.in/web/guest/document-detail?documentId=5625747>), wherein Insurer has been asked to collect premium after acceptance of proposal, however it would be difficult for me to subsequently submit premium at later stage to the insurer and hence I hereby request and authorize Insurer to accept my premium along with this proposal, to avoid any inconvenience to me, at my sole cost and consequences.

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

Date: _____

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

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

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

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

Instructions:

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

Date: DD MM YYYY

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 | | | | | | | | | | | | | | | | | | | |
| Date of Birth* | <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; text-align: center;">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"/> | is the Payor: <input type="checkbox"/> | | | | | | | | | | | |
| D | D | M | M | Y | Y | Y | Y | | | | | | | | | | | | | | | | | | | | |
| Beneficial Owner Name* <small>(as in bank account)</small> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">F</td> <td style="border: 1px solid black; width: 20px; text-align: center;">I</td> <td style="border: 1px solid black; width: 20px; text-align: center;">R</td> <td style="border: 1px solid black; width: 20px; text-align: center;">S</td> <td style="border: 1px solid black; width: 20px; text-align: center;">T</td> <td style="border: 1px solid black; width: 20px;"></td> <td style="border: 1px solid black; width: 20px;"></td> <td style="border: 1px solid black; width: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; text-align: center;">I</td> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; text-align: center;">L</td> <td style="border: 1px solid black; width: 20px; text-align: center;">E</td> <td style="border: 1px solid black; width: 20px;"></td> <td style="border: 1px solid black; width: 20px;"></td> <td style="border: 1px solid black; width: 20px; text-align: center;">L</td> <td style="border: 1px solid black; width: 20px; text-align: center;">A</td> <td style="border: 1px solid black; width: 20px; text-align: center;">S</td> <td style="border: 1px solid black; width: 20px; text-align: center;">T</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* <small>(As per the KYC proof submitted)</small> | Address 1: <input style="width: 100%;" type="text"/> | | Address 2: <input style="width: 100%;" type="text"/> | | Landmark: <input style="width: 100%;" type="text"/> | | | | City*: <input style="width: 50%;" type="text"/> | | | | Town (District): <input style="width: 50%;" type="text"/> | | | | | | | | | | | | | | |
| | State*: <input style="width: 80%;" type="text"/> | | | | Pin Code*: <input style="width: 40%;" type="text"/> | | | | | | | | | | | | | | | | | | | | | | |
| Present Address* <small>(As per the KYC proof submitted)</small> | Address 1: <input style="width: 100%;" type="text"/> | | Address 2: <input style="width: 100%;" type="text"/> | | Landmark: <input style="width: 100%;" type="text"/> | | | | City*: <input style="width: 50%;" type="text"/> | | | | Town (District): <input style="width: 50%;" type="text"/> | | | | | | | | | | | | | | |
| | State*: <input style="width: 80%;" type="text"/> | | | | Pin Code*: <input style="width: 40%;" type="text"/> | | | | | | | | | | | | | | | | | | | | | | |
| Email Address* | Address 1: <input style="width: 100%;" type="text"/> | | Address 2: <input style="width: 100%;" type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone Number(s) | Mobile*: <input style="width: 50%;" type="text"/> | | Residence (Optional): <input style="width: 50%;" type="text"/> | | Office(Optional): <input style="width: 100%;" type="text"/> | | | | | | | | | | | | | | | | | | | | | | |
| Customer Goods & Service Tax Identification Number (if any): | <input style="width: 100%;" type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Residential Status* | Indian <input type="checkbox"/> | | NRI <input type="checkbox"/> | | If NRI, Please mention country _____ | | | | Other (Please specify) <input style="width: 100%;" type="text"/> | | | | | | | | | | | | | | | | | | |
| PAN Card Number* | <input style="width: 100%;" 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 <small>(Please mention only last four digits of your Aadhaar or VID)</small> | <input style="width: 40%;" type="text"/> | | | | Document Expiry date: | | | | <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> </tr> </table> | | | | D | D | M | M | Y | Y | Y | Y | | | | | | | |
| D | D | M | M | Y | Y | Y | Y | | | | | | | | | | | | | | | | | | | | |
| CKYC number | <input style="width: 40%;" type="text"/> | | | | EIA number: <input style="width: 40%;" type="text"/> | | | | | | | | | | | | | | | | | | | | | | |
| PEP or relative of PEP | <input style="width: 100%;" type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |