

MANIPALCIGNA PROHEALTH SELECT

PORTABILITY FORM

PART I

Name of the Product: Sum Insured: i. Cumulative Bonus: Add-ons/riders taken: Policy Number: ETAILS OF THE PROPOSED INSURANCE: Name of the product proposed/intend to take: Sum Insured Proposed: i. Whether Cumulative Bonus to be converted to an enhanced sum insured: Reason(s) for Portability: Ido. of family members to be included in the policy to be ported: Enclosure: Photocopy of the existing policy documents	mail: ddress: lity: In code: TAILS OF EXISTING INSURER: Name of the Product: Sum Insured: Cumulative Bonus: Add-ons/riders taken: Policy Number: TAILS OF THE PROPOSED INSURANCE: Name of the product proposed/intend to take: Sum Insured Proposed: Whether Cumulative Bonus to be converted to an enhanced sum insured: easson(s) for Portability: o. of family members to be included in the policy to be ported: Inclosure: Photocopy of the existing policy documents ART II ART II ART II Thether the PED exclusions/ time bound exclusions have longer exclusion period than the existing policy. (Please indicate Yes/ No) Yes No Yes please give written consent to the declaration below: am aware that the waiting period for the following diseases(s)/treatment(s) is days/ years more than the previous policy terms.	lame of the Policy Holder/Ir	sured(s)):	=	R	S	Т				M	-	D	D	L	Е						U	R	Ν	А	M	Е	
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MANIPALCIGNA PROHEALTH SELECT

PORTABILITY FORM (ANNEXURE)

SECTION A. PERSONAL DETAILS OF POLICYHOLDER/ INSURED:

i) Proposal Number								
ii) Existing Insurance I	Details							
1. Please indicate wh	ether covered ur	nder: Group P	Policy	Retail Policy				
2. Have you extended	d your current po	licy on short ter	m basis?	Yes	No			
	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insure	d 7 Insured 8
Name								
Policy 1 DOJ (DD/MM/YYYY)								
Sum Insured								
Policy Type								
Cumulative Bonus								
Policy 2 DOJ (DD/MM/YYYY)								
Sum Insured								
Policy Type								
Cumulative Bonus								
Policy 3 DOJ (DD/MM/YYYY)								
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Policy Type								
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Policy 4 DOJ (DD/MM/YYYY)								
Sum Insured								
Policy Type								
Cumulative Bonus								
DOJ - Date of joining	g DDMN	Л Ү Ү Ү	Policy	y Type - Indiv	idual or Floater			
iii) Pre- Existing Details	s							
Pre-exiting details for	Proposed Insure	ed Persons (The	e below section	n is mandator	y. Please fill in NII	where the sec	tion is not	applicable.)
S.no	Nan	ne	PE	D declared	No. of years of Continuous Co	Waiting comple	period ted	Waiting period remaining
Insured 1								
Insured 2								
Insured 3								
Insured 4								
Insured 5								
Insured 6								
Insured 7								
Insured 8								

Documents to be provided:

1. Policy Schedule for the previous year(s) as available.

2. Renewal notice for the expiring policy

Acceptance of Portability is subject to the following

- 1. Application for Portability to ManipalCigna Health Insurance Company Limited is made at least 45 days before the policy renewal date of current insurance policy
- 2. Availability of relevant medical / Claim history from previous insurer.
- 3. Risk acceptance by Underwriting on evaluation of Proposal form or any Pre Policy Health Check up/ additional information.
- 4. Acceptance of revised offer (if any) must be provided within 7 days of intimation.
- 5. The company shall not be liable if the application is rejected due to non-adherence to the above guidelines.

Declarations I understand that my application for portability is being processed and some deproposed risk. In absence of receipt of the same before expiry of my existing process my application based on the information furnished along with the subsequently found, ManipalCigna Health Insurance Company Limited shall endorsement and/or take these into consideration while adjudicating any claims with current insurer to ensure no break in coverage and shall intimate the same in	olicy, I authorize ManipalCigna Health Insurance Company Limited to upporting documents provided herein. However, if any variance is at its discretion cancel/ modify my coverage through appropriate under this policy. I also understand that I can extend my existing policy writing to ManipalCigna Health Insurance Company Limited in case of
no written communication regarding acceptance of proposed risk on or before exp	orry of my existing policy.

SECTION B: FOR MANIPAL CIGNA OPERATIONS TEAM ONLY: The below section is mandatory

i. Details available from previous insurer: Yes No
1. Claim history: Positive Negative 2. PED History: Positive Negative
ii. Declaration in Proposal and Portability Form: Fill in Yes/ No as applicable
1. Medical Declarations: Positive Negative iii. PPMC Applicable for any person in the policy: Yes No
Name of Customer for whom PPMC is applicable for the customer
Insured 1:
Insured 2:
Insured 3:
Insured 4:
Insured 5:
Insured 6:
Insured 7:
Insured 8:

ManipalCigna ProHealth Select | UIN: MCIHLIP25025V042425 | May 2024