(Formerly known as CignaTTK Health Insurance Company Limited)

Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063.

IRDAI Registration No. 151 Call (Toll Free): 1800-102-4462

Visit: www.manipalcigna.com E-mail: customercare@manipalcigna.com



MANIPALCIGNA PROHEALTH INSURANCE

Migration Form

PART I

. Da		nsured (s):	F I R		Т		1	M			D	L E	-								\wedge	M		
	te of Birth: DD M		Y Y	А	ge:		(Years	5)																
Ad	dress of the policyholder/ii	nsured:																						
mai	l:			Щ																				
ity (District):			S	tate:																			
in c	ode:																							
. De	etails of existing insurer:																							
i.	Name of the product:																							1
ii.	Sum Insured:																							4
iii.	Cumulative Bonus:																				_			_
iv.	Add-ons/riders taken:																							
٧.	Policy number:																							
. De	tails of the proposed insur	ance																						
i.	Name of the product pro	posed/inten	d to take:																					
ii.	Sum Insured Proposed:																							
iii.	Whether Cumulative Bo	nus to be co	nverted to	o an e	nhar	iced su	m insu	red:																
Encl	osure: Photocopy of the e	xisting policy	docume	ents																				
														<u>.</u> .										
Date	e: DDMMYYY	YY												Sigr	natu	ire c	fth	ie P	olic	уH	olde	er		
	RT II																							
PAF						Whether the PED exclusions / time bound exclusion have longer exclusion period than									(Please indicate Yes / No)									
PAF	Whether the PED exclu	sions / time	bound ex	clusic	n ha	ve long	er excl	usior	per	iod	than			(Pl	eas	e in	dica	ate `	Yes	/ N	၁)			
	1	sions / time	bound ex	clusic	on ha	ve long	er excl	usior	per	iod	than			(PI		e in	dica	ate `		/ No				
	Whether the PED excluthe existing policy													YE	S					NO				
1.	Whether the PED exclu	been diagno	sed or su	uspect	ed to	have a	any hea	alth is						YE (Pl	: S eas	e in			Yes	NO / No	D)			
1.	Whether the PED excluthe existing policy Has any of the insured	been diagno	sed or su	uspect	ed to	have a	any hea	alth is						YE	: S eas				Yes	NO	D)			
1. 2.	Whether the PED excluthe existing policy Has any of the insured common cold, flu, fever aswer to the Question 1 is	been diagno , loose motic	sed or su	uspect	ed to	have a	any hea us poli	alth is	sue	exc				YE (Pl	: S eas				Yes	NO / No	D)			
1. 2. If an Dec	Whether the PED excluthe existing policy Has any of the insured common cold, flu, fever to the Question 1 is laration	been diagno ; loose motic 'Yes', please	sed or su ons post is	uspect ssuan	ed to	have a previo	any hea us poli	alth is cy? ration	sue	exc	ept	the "	Miar	YE (PI	eas	e in	dica	ate `	Yes	NO / No NO	D)	the	Ine	וויםיו
1. 2. If an Dec	Whether the PED excluthe existing policy Has any of the insured common cold, flu, fever aswer to the Question 1 is	been diagno ; loose motio 'Yes', please	sed or su ons post is give writ	uspect ssuan	ed to	have a previo	any hea us poli	alth is cy? ration	sue	exc	ept	the 'I	Migra	YE (PI	eas	e in	dica	ate `	Yes	NO / No NO	D)	the	Insu	ıraı
1. 2. If an Dec	Whether the PED excluthe existing policy Has any of the insured common cold, flu, fever to the Question 1 is laration aware that waiting period	been diagno ; loose motio 'Yes', please	sed or su ons post is give writ	uspect ssuan	ed to	have a previo	any hea us poli	alth is cy? ration	sue	exc	ept	the 'I	Migra	YE (PI	eas	e in	dica	ate `	Yes	NO / No NO	D)	the	Insu	ıraı
1. 2. If an Dec	Whether the PED excluthe existing policy Has any of the insured common cold, flu, fever to the Question 1 is laration aware that waiting period	been diagno ; loose motio 'Yes', please	sed or su ons post is give writ	uspect ssuan	ed to	have a previo	any hea us poli	alth is cy? ration	sue	exc	ept	the 'I	Migra	YE (PI	eas	e in	dica	ate `	Yes	NO / No NO	D)	the	Insu	ıraı
1. 2. f an Dec	Whether the PED excluthe existing policy Has any of the insured common cold, flu, fever to the Question 1 is laration aware that waiting period	been diagno ; loose motio 'Yes', please	sed or su ons post is give writ	uspect ssuan	ed to	have a previo	any hea us poli	alth is cy? ration	sue	exc	ept	the 'I	Migra	YE (PI	eas	e in	dica	ate `	Yes	NO / No NO	D)	the	Insu	ıraı

Signature of Policy Holder

ManipalCigna ProHealth Insurance | Migration Form | UIN: MCIHLIP25024V082425 | May 2024

PART III

Please fill the following details with respect to claims in health insurance policy(ies) currently held with the Company (Individual or Group)?

Insured	Policy Number	Type of Policy e.g. Mediclaim, PA, CI, Hospital Cash	Claim Number	Claimed Amount	Ailment
Insured 1					
Insured 2					
Insured 3					
Insured 4					
Insured 5					

Please Note: Migration and issuance will be subject to complete UW /medical assessment and basis UW guidelines.