roposal Form No.:	Corporate Office: 401/402 Goregaon (E), Mumbai - 40 Call (Toll Free): 1800-102-	urance Company Limited TTK Health Insurance Company Lir 2, Raheja Titanium, Western Expres 00063. IRDAI Registration No. 1514462 Visit: www.manipalcigna.com	s Highway, m	_	oal Cigno
Photograph of Insured 1	Photograpi Insured		Photograph of Insured 3		Photograph of Insured 4
Photograph of Insured 5	Photograpi Insured		Photograph of Insured 7		Photograph of Insured 8
		FOR OFFICE USE ONLY			
Branch Name:		Bran	ch Code:		
		Inter	mediary Code: Agent Co	ode / Broker Code / CA C	ode
Intermediary Name: Business Type: Urban /Social Ops Tags: Employee DMS C Sub Intermediary Name < <for a="" b<="" ef.="" p="" th=""><th>Code: ManipalCigna Employee DMS C</th><th>Sub Intermediary PAN <<for< th=""><th>POSP>></th><th>Partner Branch II Other Details <<f< th=""><th>D: Partner Branch Code For POSP>></th></f<></th></for<></th></for>	Code: ManipalCigna Employee DMS C	Sub Intermediary PAN < <for< th=""><th>POSP>></th><th>Partner Branch II Other Details <<f< th=""><th>D: Partner Branch Code For POSP>></th></f<></th></for<>	POSP>>	Partner Branch II Other Details < <f< th=""><th>D: Partner Branch Code For POSP>></th></f<>	D: Partner Branch Code For POSP>>
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ManipalCigna ProHealth Cash | Proposal Form | UIN: MCIHLIP21556V042021 | URN: 2020/PCSH/V2.02 | October 2024

Would y	you like to subscribe to important alert on Whatsapp? Yes	es No
Policyh	holders have the option to access their Policy documents thr	rough DigiLocker with no additional charges.
To learn	rn more about DigiLocker, please visit https://www.manipalci	signa.com/video/
Would y	you prefer to receive all policy document digitally (via email.	il/soft copy)?
Ye	es (I would like to receive policy document digitally).	No (I prefer to receive policy document in hard copy).
Occupa		Service Self Employed Others
	Il Income* : Up to ₹50,000 ₹5 to ₹10	
, unidai	₹50,000 to ₹5 Lacs ₹10 to ₹1	
Cdaati		
	tional Qualification* : Less than class X Class X mer Goods & Service Tax Identification Number (if any):	Class XII Graduate Post Graduate Professional Degree
	ential status* : Indian NRI If NRI, Please menti	tion country Others (Please specify)
		Others (Flease specify)
	Card Number* :	
	60* (only in case where PAN number is not available) Yes	No
Identity	y Document Type : Aadhaar Card	Passport Voter's ID card Others
VID Nu	umber (Please mention only last four digits of your Aadhaar^^ or VID):	
CKYC r	number :	EIA number:
PEP or	r relative of PEP:	
Family	y Physician Details:	
Name	: FIRSTNAME	E
Contact	ct number :	Email id:
Address	ss :	
Do vou	u wish to assign a Caregiver for your Policy/ies: Yes	No If Yes, please provide:
Name*		
Mobile i	number* :	Relationship with Proposer:
Age (in	n Years) :	Email id:
		on in any kind of health care event, whether emergency or planned. The Caregiver might not be the SOS contact.
	·	
···Please p	e provide the details to enable us to serve you better.	
	MINEE DETAILS*: minee same as Caregiver (if provided above)? Yes No. If No, please	o provide Naminos detaile
S. No.	Ţ (e provide Nominee details. Nominee 1 Nominee 2 Nominee 3
1		Nonlinido 1
_	Name	
2	Age	
3	Mobile No.	
4	Email ID	
5	Correspondence Address	
6	Permanent Address	
7	Relationship with Proposer	
8	Specify the percentage (%) of the claim amount payable	
	to each nominee in the event of the policyholder's death. The total percentage of contribution across all the	
	nominee must not exceed 100%	
9	Bank Details of Nominee	
	Account No. IFSC/MICR Code	
	Name of Bank Account Holder Name	
10	Appointee Details (Required only if nominee is a minor)	
'0	Name Age*	
	Mobile No.	
	E-mail ID Relationship with Nominee	
	<u> </u>	1

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

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

*A Minor should not be declared as Appointee.

III. POLICY/PLAN DETAILS*:

III. POLICT/PLAN DETAILS .	
Tenure*: 1 Year 2 Years 3 Years	Proposed Policy Period: From D D M M Y Y Y Y at : Hrs
	(Must be on or later than instrument date/ premium payment date)

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NS	URFD	DETAIL	S*: (Daily C	ash Renefit and	Sum Insured	only for individual	COVE

Sr No.	Name (First*,Middle, Last*)	Gender* (M/F/O)	DOB*	Relationship with Proposer*	ABHA Number ^^	Height* (Cms)	Weight* (Kgs)	Occupation/ Industry Type/ Nature of Job*	City*	Gainful Annual Income	Daily Cash Benefit*	Sum Insured for Accidental Death & Permanent Total Disability Cover (if opted)	Insured Address If Different From Proposer	If PEP/ Relatives of PEP^ (Y/N)
1														
2														
3														
4														
5														
6														
7														
8														
^Polit	ically exposed person		1	1		-			1					

^Politically	exposed	person
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*All Insureds are Indian national and Indian residents? Yes 1	No
If No, Please mention country	

Note:

ManipalCigna Critical Illness Add On Cover: Minimum age at entry under this policy is 18 years and maximum age at entry is 65 years.

ManipalCigna ProHealth Cash: The minimum entry age under this policy is 91 days and maximum age at entry is 65 years. To avail the Optional Cover for Accidental Death & Permanent Total Disability the minimum entry age is 5 years.

Plan Option: Please choose the Plan Option You seek: Basic Plan Baily Cash Benefit*: Please Choose the Daily Cash Benefit You want to choose		Premium Installment Option:	Optional Covers:	Plan Limit*:	
₹ 500 ₹ 1500	₹ 1000 ₹ 2000	Single	Day Care Treatment Benefit	60 days	
₹ 2500 ₹ 3500 ₹4500	₹ 3000 ₹ 4000 ₹ 5000	Annual	Accidental Death & Permanent Total Disability Cover	180 days	
ManipalCigna Critic	al Illness Add On Cover	1	1	I	

Applicable Discounts:

- a. Family Discount of 10% for covering 3 or more family members under the same policy.
- Long Term policy discount of 7.5% and 10% on selecting a 2 and 3 years policy term respectively. Long Term discount will apply only in case of Single

.	Worksite Marketing Discount	Worksite Code:	Employee id:

Online Renewal Discount a discount of 3% p.a. if the customer chooses for NACH or standing instruction (where payment is made either by direct debit of bank account or credit card) option, applicable from next renewal of the policy

Note: Please note that your Policy period will start from premium received date at our branch office in case of cash payments or/ as per instrument date when paying through Cheque/ demand draft/ pay order. In case of credit card/ debit card transactions, Policy period will start from date of debit of requisite premium from the Proposer's card/ bank account.

If PEP details are not provided, we will consider the same as "No".

^{^^^}Please provide ABHA number (Ayushman Bharat Health Account number) for all the proposed Insured Persons. In case the ABHA number is not available for any Insured Person, you may request to create an ABHA number by visiting the web link: https://healthid.ndhm.gov.in/register.

	WEDICAL AND LIFESTYLE INFORMATION":						1		1
	dical questions	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q1	Has any of the applicants ever been diagnosed with or suspected to have Cancer or Rheumatoid Arthritis or Ulcerative Colitis or Crohn's disease or Chronic Liver Disease, Hepatitis B, Cirrhosis or Chronic Kidney Disease or Kidney failure or Epilepsy or Fits or Stroke or Paralysis or Parkinsonism or Alzheimer's or Multiple sclerosis or Brain Tumor or Cerebral Palsy or Heart Failure or Heart Attack or Angina or Coronary Artery Disease or Ischemic Heart Disease or Chronic Bronchitis or	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
	Intestitial Lung Diseases or Pneumoconiosis or Emphysema.								
Q2	Has any member ever suffered or currently suffering from or under treatment (operated, hospitalised, investigated) or been under medication for more than a week for any medical condition.	YES	YES	YES	YES NO	YES NO	YES	YES	YES
I	Diabetes Mellitus	YES	YES	YES	YES	YES	YES	YES	YES
II	Hypertension	YES	YES	YES	YES	YES	YES	YES	YES
III	High Cholesterol	YES	YES	YES	YES	YES NO	YES	YES	YES
IV	Thyroid disorders	YES	YES	YES	YES	YES	YES	YES	YES
V	Heart and Lung disorders	YES	YES	YES	YES	YES	YES	YES	YES
VI	Digestive system disorders (Stomach and related organs)	YES NO	YES	YES	YES	YES NO	YES	YES	YES
VII	Brain, nerve and Psychiatric (Mental) disorders	YES NO	YES	YES	YES NO				
VIII	Other Endocrine (Hormonal) disorders	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
IX	Bone, joints and muscle disorders	YES NO	YES	YES	YES NO				
Х	Ear, nose, eye and throat disorders	YES NO	YES	YES	YES NO				
ΧI	Genito-urinary and Gynaecological disorders	YES NO	YES	YES	YES NO				
XII	Blood and related disorders	YES NO	YES	YES	YES NO				
XIII	Skin disorders	YES NO YES	YES NO YES	YES NO	NO YES	YES NO	NO YES	NO YES	NO YES
XIV	Any other condition / illness / disorder / surgery	NO NO	NO NO	NO NO	NO NO	NO NO	NO NO	NO NO	NO NO
Q3	Has any of the applicants recommended to undergo or has undergone any pathologic or radiologic tests for any illness other than the ones listed above and routine or annual health check-up?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Q4	Is any applicant currently not in good health and undergoing any investigation or treatment or medication for any illness or medical condition (Physical/ Mental/ Sleep disorders)?	YES NO	YES	YES	YES NO				
На	bits and Lifestyle questions	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q5	Does any of the insured/s chew tobacco/ smoke/ consume alcohol? Please tick the relevant box(es) below	YES	YES NO	YES	YES	YES NO	YES	YES	YES
Α	Smoke	YES	YES NO	YES NO	YES	YES NO	YES	YES NO	YES
1	Since how long does the applicant smoke								
а	<=20 years								
b	>20 years								
В	Tobacco	YES	YES	YES	YES	YES	YES	YES	YES
1	How many Pan masala / gutka packets does the applicant has in a day								
а	1-3 packets/day								
b	4-6 packets/day								
ر	>6 nackets/day								

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С	Alcohol	YES							
		NO							
1	How frequently does the applicant consume alcohol								
а	1-3 days/ week								
b	3-6 days / week								
С	Daily								
Fo	r Accidental Death/PTD Cover	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q6	Has any of the applicants suffered or currently suffering from seizure disorder or any physical or mental defects/impairment/infirmity/ deformity or any condition that may effect mobility/sight/hearing/ speech?	YES							
Q7	Does the applicant's occupation require him/her to engage in manual lab our or hazardous activities or handling hazardous material or working at heights, as cabin crew, in sea/river faring vessels, with high voltage, or be a part of armed forces?	YES	YES NO						
Fo	r Critical Illness Add On Cover	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q8	Have any first degree relatives (i.e. parents, brothers, sisters or children) of any of the applicants (who are not themselves applicants for this insurance policy) had cancer, motor neuron disease or any other hereditary disorders.	YES	YES NO	YES NO	YES	YES	YES	YES	YES

V. ADDITIONAL MEDICAL INFORMATION:

If answers to Q2 are 'Yes', please provide further details below. Please attach extra sheets if required.

Sr.No.	Additional Medical Information	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
a.	Exact Diagnosis								
b.	Year of diagnosis								
C.	Treatment taken : Surgical/ Medical / No treatment / Defaulter (left treatment on own)								
d.	Current status - Cured/ On treatment / Pending surgery or treatment								
e.	Complications/ Recurrences - Yes/No								
f.	Last consultation date - "Month/ Year" to be provided								
G.	Histopathology Examination Report (only for surgical) - No abnormality, Malignancy/borderline malignancy/ Tuberculosis								

Signature of Proposer *:

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

VI. PREVIOUS/CURRENT INSURANCE DETAILS:

Pease fill the following details with respect to health insurance policies(s) currently or held with the Company or any other insurance company (Individual or Group)?

Insured	Policy No.	Type of Policy e.g. Mediclaim, PA, CI, Hospital Cash	Insurer Name	From Date	To Date	Sum Insured		Claim Details Cumulative Bonus Earned				Has any proposal for life, health, hospital daily cash or critical illness insurance on the life of the applicant ever been declined, postponed, loaded or been made subject to any special conditions such as
							Claim Number	Claimed Amount	Ailment	%	Amount	exclusions by any insurance company?
Insured 1												☐ YES ☐ NO
Insured 2												☐ YES ☐ NO
Insured 3												YES NO
Insured 4												YES NO
Insured 5												☐ YES ☐ NO
Insured 6												☐ YES ☐ NO
Insured 7												YES NO
Insured 8												YES NO

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IX. 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 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, including seeking and/or sharing of my medical data through ABHA.

I hereby consent to and authorize ManipalCigna Health Insurance Company Limited ("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 authorised 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.

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Date: D D M M Y Y Y Place:

Signature of Proposer *:_

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

X. VERNACULAR DECLARATION:

I hereby declare that, I have fully explained the contents of the proposal form and terms and conditions of the Policy to the Proposer in the language understood to him/her and that the Proposer has affixed the thumb impression above after fully understanding the contents thereof.

Date: DDMMYYYY Place:

Signature of Proposer *:

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

XI. ADVISOR / INTERMEDIARY DECLARATION*:

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: DDMMYYYY

Place:

Signature of Agent:

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 out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurer.
- $2. \ \, \text{Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.}$

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Note: Neither the submission of a completed proposal for insurance or any payment for any Policy sought oblige the Company to agree to issue a Policy, which decision is and always shall be in the Company's sole and absolute discretion.

If ManipalCigna Health Insurance Company Limited accepts a proposal for insurance, it shall be subject to the board approved underwriting policy of the Company and the Policy terms and conditions of this product and the Company shall have no liability to make any payment if premium is not received by ManipalCigna Health Insurance Company Limited in full and in time, or is not realised.

Should you choose to pay premium by Cash, you are advised to do so only at the nearest ManipalCigna branch or its authorised collection points. Handing over cash to any Advisor/Employee is solely at your own risk and the Company shall in no way be held responsible for any loss in this regard.

Insurance is a subject matter of solicitation.