Proposal Form No.:

ManipalCigna Health Insurance Company Limited
(Formerly known as CignaTTK Health Insurance Company Limited)
Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (E), Mumbai - 400063. IRDAI Registration No. 151.
Call (Toll Free): 1800-102-4462 **Visit:** www.manipalcigna.com
E-mail: customercare@manipalcigna.com **CIN No**.: U66000MH2012PLC227948

ManipalCigna Health Insurance

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

FOR OFFICE USE ONLY

Branch Name:	Branch Code:
Intermediary Name:	Intermediary Code: Agent Code / Broker Code / CA Code
Business Type: Urban /Social / Rural	
Ops Tags: Employee DMS Code: ManipalCigna Employee DMS Code	Partner Vertical Name: Partner Business Vertical Code / Partner Branch ID: Partner Branch Code

Ref. A
Ref. B

MANIPALCIGNA SARVAH - PRATHAM
PROPOSAL FORM

Ref. C

1 Please fill the form in BLOCK LETTERS. 2 All details marked with * are mandatory. 3 The Proposer must authenticate the cancellations/alterations in this form.

For Staff Rebate# please provide: Name of the organization: _____

Name of the Employee: _____ Employee ID: _____

#(Applicable only if Proposer or any Insured person under the policy is employee of: ManipalCigna, Promoter group of ManipalCigna)

The issuance of this form by ManipalCigna Health Insurance Company Limited (the Company) does not amount to acceptance of proposal. The actual liability of the Company does not commence until this proposal has been accepted by the Company and premium realized.

I. PROPOSER DETAILS*:

Title* : Mr. Mrs. Ms. Gender* : Male Female Others Tick if Employer is the Payor:

Date of Birth* : D D M M Y Y Y Y Marital Status* : Married Single Others

Name*(as in bank account): FIRSTNAME* MIDDLENAME SURNAME*

Permanent Address*: (As per the KYC proof submitted):

Landmark:

City*: Town (District):

State*: Pin Code*:

Gram Panchayat:

Correspondence Address*:

If same as above, please tick here

Landmark:

City* : Town (District):

State*: Pin Code*:

Gram Panchayat:

Email Address* : Address 1 Address 2

Telephone Number(s) : Mobile*: Residence (Optional):

Office(Optional):

Would you like to subscribe to important alert on Whatsapp? Yes ☐ No ☐

Policyholders have the option to access their Policy documents through DigiLocker with no additional charges.

To learn more about DigiLocker, please visit https://www.manipalcigna.com/video/

Would you prefer to receive all policy document digitally (via email/soft copy)?

☐ Yes (I would like to receive policy document digitally). ☐ No (I prefer to receive policy document in hard copy).

Occupation* : Government Service ☐ Private Service ☐ Self Employed ☐ Others ☐ _____

Annual Income* : Up to ₹50,000 ☐ ₹5 to ₹10 Lacs ☐ ₹15 to ₹20 Lacs ☐

₹50,000 to ₹5 Lacs ☐ ₹10 to ₹15 Lacs ☐ Above ₹20 Lacs ☐

Educational Qualification* : Less than class X ☐ Class X ☐ Class XII ☐ Graduate ☐ Post Graduate ☐ Professional Degree ☐

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

Residential status* : ☐ Indian ☐ NRI If NRI, Please mention country _____ ☐ Others (Please specify) _____

PAN Card Number* :

Form 60* (only in case where PAN number is not available) Yes ☐ No ☐

Identity Document Type : Aadhaar Card ☐ Driving License ☐ Passport ☐ Voter's ID card ☐ Others ☐

Aadhaar number^^/ (VID number) :

CKYC number : EIA number:

PEP or relative of PEP:

Family Physician Details:

Name : FIRSTNAME MIDDLENAME SURNAME

Contact number : Email id:

Address :

Do you wish to assign a Caregiver for your Policy/ies: Yes ☐ No ☐ If Yes, please provide:

Name* : FIRSTNAME* MIDDLENAME SURNAME*

Mobile number* : Relationship with Proposer:

Age (in Years) : Email id:

Caregiver can be a close family member who would take care of the Insured Person in any kind of health care event, whether emergency or planned. The Caregiver might not be the SOS contact.

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

II. 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	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) Name Age# Mobile No. E-mail ID Relationship with Nominee			

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*:

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)

INSURED DETAILS*: (Deductible and Sum Insured only for individual cover)

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Name (First*, Middle, Last*)								
Gender*								
DOB*								
Relationship with Proposer*								
ABHA Number^^^								
Height* (Cms)								
Weight* (Kgs)								
Gainful Annual Income* (In Case Personal Accident Cover is opted)								
Occupation/ Industry Type/ Nature of Job*								
City*								
Deductible								
Sum Insured* (only for individual cover and Multi-individual cover)								
Insured address if different from Proposer								
If PEP/Relatives of PEP ^ (Yes / No)								
CKYC Number								

Optional Covers	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5
Personal Accident Cover (AD, PTD & PPD)	☐ 10L, ☐ 15L, ☐ 20L, ☐ 25L, ☐ 30L, ☐ 40L, ☐ 50L, ☐ 1Cr, ☐ 2Cr, ☐ 3Cr	☐ 10L, ☐ 15L, ☐ 20L, ☐ 25L, ☐ 30L, ☐ 40L, ☐ 50L, ☐ 1Cr, ☐ 2Cr, ☐ 3Cr	☐ 10L, ☐ 15L, ☐ 20L, ☐ 25L, ☐ 30L, ☐ 40L, ☐ 50L, ☐ 1Cr, ☐ 2Cr, ☐ 3Cr	☐ 10L, ☐ 15L, ☐ 20L, ☐ 25L, ☐ 30L, ☐ 40L, ☐ 50L, ☐ 1Cr, ☐ 2Cr, ☐ 3Cr	☐ 10L, ☐ 15L, ☐ 20L, ☐ 25L, ☐ 30L, ☐ 40L, ☐ 50L, ☐ 1Cr, ☐ 2Cr, ☐ 3Cr
Temporary Total Disablement (TTD) (per week Sum Insured options)	☐ 5,000 ☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000	☐ 5,000 ☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000	☐ 5,000 ☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000	☐ 5,000 ☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000	☐ 5,000 ☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000

^ Politically exposed person.

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

*Are all insured Indian National and Indian Residents? ☐ Yes ☐ No If No, Please mention country ____________________

Plan Type*: Individual ☐ Floater ☐ | **Portability*:** Yes ☐ No ☐ (If yes portability form to be completed and attached) | **Migration*:** Yes ☐ No ☐ (If yes migration form to be completed and attached)

Sum Insured (for individual or floater policy)

₹5 Lacs ☐ ₹7.5 Lacs ☐ ₹10 Lacs ☐ ₹15 Lacs ☐ ₹20 Lacs ☐ ₹25 Lacs ☐ ₹50 Lacs ☐ ₹100 Lacs ☐ ₹200 Lacs ☐ ₹300 Lacs ☐

Premium payment mode: ☐ Monthly^ ☐ Quarterly ☐ Half yearly ☐ Single

^3 months premium to be paid in advance and instalment/renewal premium payment through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card).

Optional Covers

1. **Accidental Hospitalization**
   ☐ Yes ☐ No
2. **Health Check-up**
   ☐ Yes ☐ No
3. **Air Ambulance**
   ☐ Yes ☐ No
4. **Restoration of Sum Insured**
   ☐ Yes ☐ No
5. **Gullak**
   ☐ Guaranteed 100% increase in Sum Insured per year, maximum up to 1,000% irrespective of claim under the Policy.
6. **Sarathi**
   ☐ Yes ☐ No
7. **Room Rent Modification**
   ☐ Option 1: Any room; ICU Up to Sum Insured
   or
   ☐ Option 2: Twin Sharing AC room; ICU Up to Sum Insured
8. **Surplus Benefit**
   ☐ Yes ☐ No
9. **Deductible**
   ☐ **Option - 1: Aggregate Deductible**
   ☐ 10,000 ☐ 25,000 ☐ 50,000 ☐ 1,00,000 ☐ 2,00,000 ☐ 3,00,000 ☐ 4,00,000 ☐ 5,00,000 ☐ 10,00,000
   or
   ☐ **Option - 2: Daily Deductible**
   ☐ 1,000/day ☐ 2,000/day ☐ 3,000/day ☐ 4,000/day ☐ 5,000/day
10. **Voluntary Co-Payment**
    ☐ 10% ☐ 20% ☐ 30%
11. **Coverage for Non-Medical Items and Durable Medical Equipment's**
    ☐ Yes ☐ No

Note:

- **Personal Accident Cover:** The minimum entry age under the policy is 5 years and maximum age at entry is 65 years. In case of Family Option – Sum Insured for Non-earning spouse/live-in partner will be limited to 60% of the Proposer and for Dependents (Children/Parents/In-laws) will be limited to 30% of the Proposer, subject to maximum Rs. 30 Lacs.
- **TTD Cover:** Available only for earning member. This will be available if Personal Accident Cover is opted.
- Optional Cover - 'Sarathi' is available only during the first Policy Year and not available during renewal. Once opted cannot be opted out in the subsequent renewals.
- Voluntary Co-payment and Deductible cannot be opted at same time.

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.

IV. MEDICAL AND LIFESTYLE INFORMATION*:

	Medical questions	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q1	Has any of the applicants have ever been diagnosed with or suspected to have any of the following disease/ ailment:	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
i	Cancer or leukaemia or Tumour	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
ii	HIV/ AIDS/Sexually transmitted diseases or Auto immune diseases - Rheumatoid Arthritis / Ulcerative Colitis / Crohn's disease/Systemic lupus erythematosus	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
iii	Chronic Liver Disease, Hepatitis B & C, Cirrhosis, Pancreatitis	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
iv	Chronic Kidney Disease / Kidney failure, Dialysis	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
v	Diseases of the Brain-Stroke/Paralysis/Parkinsonism / Alzheimer's/ Multiple sclerosis/Dementia (Memory loss)/Brain Tumor/ Cerebral Palsy/ Transient Ischemic Attack	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
vi	Diseases of heart-Ischemia/Coronary artery disease/ Cardiomyopathies /Valvular diseases/ Sinus rhythmic changes/ Pacemaker insertion / Rheumatic heart disease / Deep vein thrombosis	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
vii	Chronic diseases of the Lungs - Chronic Bronchitis/ Interstitial Lung Diseases/ Pneumoconiosis/ Emphysema/ Chronic obstructive pulmonary disease	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
viii	Bone tumors/ cyst/ any sarcoma	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Q2	Has any applicants ever been operated, hospitalized, investigated, under treatment for or been under medication for any of the below medical condition:	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
i	**Diabetes Mellitus**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
ii	**Hypertension**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
iii	**High Cholesterol**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
iv	**Endocrine diseases**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Thyroid diseases/ nodule/goitre/ thyroiditis	☐	☐	☐	☐	☐	☐	☐	☐
2	Parathyroid gland disorders	☐	☐	☐	☐	☐	☐	☐	☐
3	Adrenal gland diseases	☐	☐	☐	☐	☐	☐	☐	☐
4	Pituitary tumors	☐	☐	☐	☐	☐	☐	☐	☐
5	Any other	☐	☐	☐	☐	☐	☐	☐	☐
v	**Heart and Lung disorders**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Asthma	☐	☐	☐	☐	☐	☐	☐	☐
2	Syncope	☐	☐	☐	☐	☐	☐	☐	☐
3	Chest Pain/Shortness of Breath/ Palpitations/ pedal edema	☐	☐	☐	☐	☐	☐	☐	☐
4	Chronic cough/ Hemoptysis (blood in cough)	☐	☐	☐	☐	☐	☐	☐	☐
5	Hypotension (Low Blood Pressure)	☐	☐	☐	☐	☐	☐	☐	☐
6	Lung Abscess	☐	☐	☐	☐	☐	☐	☐	☐
7	Any other heart and lung condition	☐	☐	☐	☐	☐	☐	☐	☐
vi	**Digestive system disorders (Stomach and related organs)**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Peptic ulcer (Ulcer in stomach or duodenum)	☐	☐	☐	☐	☐	☐	☐	☐
2	Chronic Colitis/Inflammatory bowel disease/Blood in stools	☐	☐	☐	☐	☐	☐	☐	☐
3	Irritable bowel syndrome	☐	☐	☐	☐	☐	☐	☐	☐

4	Any other diseases of mouth, oesophagus, stomach or intestines	☐	☐	☐	☐	☐	☐	☐	☐
5	Fatty liver	☐	☐	☐	☐	☐	☐	☐	☐
6	Any other	☐	☐	☐	☐	☐	☐	☐	☐
vii	**Brain, nerve and Psychiatric (Mental) disorders**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Seizures and chronic headaches	☐	☐	☐	☐	☐	☐	☐	☐
2	Loss of balance/ unsteadiness/dizziness	☐	☐	☐	☐	☐	☐	☐	☐
3	Vertigo/double vision	☐	☐	☐	☐	☐	☐	☐	☐
4	Any other	☐	☐	☐	☐	☐	☐	☐	☐
viii	**Ear, Nose, Eye and Throat disorders**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Vocal cord lesions (nodules, polyps and cysts)	☐	☐	☐	☐	☐	☐	☐	☐
2	Paraphyarngeal abscess	☐	☐	☐	☐	☐	☐	☐	☐
3	Any other	☐	☐	☐	☐	☐	☐	☐	☐
ix	**Genito-urinary and Gynaecological disorders**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Recurrent Urinary tract infection/blood in urine	☐	☐	☐	☐	☐	☐	☐	☐
2	Prostate Hyperplasia/ prostatitis/Prostate disorder	☐	☐	☐	☐	☐	☐	☐	☐
3	Breast lump / Cyst / abscess	☐	☐	☐	☐	☐	☐	☐	☐
4	Ovarian cyst	☐	☐	☐	☐	☐	☐	☐	☐
5	Post-menopausal uterine bleeding	☐	☐	☐	☐	☐	☐	☐	☐
6	Cervical polyp	☐	☐	☐	☐	☐	☐	☐	☐
7	Any other	☐	☐	☐	☐	☐	☐	☐	☐
x	**Blood and related disorders**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Anaemia	☐	☐	☐	☐	☐	☐	☐	☐
2	Any other	☐	☐	☐	☐	☐	☐	☐	☐
xi	**Any other condition / illness / disorder / surgery**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q3	Has any of the applicant recommended to undergo or has underwent any pathologic or radiologic tests for any illness other than the ones listed above or have undergone any 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 ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q5	Have any first degree relatives (i.e. parents, brothers, sisters or children) of any of the applicants had history of Cancer, Heart Diseases or Stroke?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q6	Has any of the applicant ever had unexplained weight loss for more than 5 kg other than weight loss program?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q7	Has any of the applicant experienced any Cyst/ lump/ growth / polyp / Changes in Mole /Lymphnode in any part of the body.	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Q8	Does any of the insured/s chew tobacco/ smoke/ consume alcohol or use any recreational drugs?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Smoke	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
2	Tobacco	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
3	Alcohol	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
4	Any other type of Drugs	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Additional Questions for Personal Accident Cover and Accidental Hospitalization (if Opted)		**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**	**Insured 7**	**Insured 8**
Q9	Has any of the applicant suffered or currently suffering from seizure disorder or any physical or mental defects/ impairment/ infirmity/ deformity or any condition that may affect mobility/ sight/ hearing/ speech?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q10	Does the applicant's occupation require him/her to engage in manual labour 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 ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

##Hazardous substances/ chemicals: Substances, chemicals, mixtures which pose a significant risk to health and safety (Inflammable or combustibles, carcinogens, Allergens, Irritants, asphyxiants, toxic gases, pesticides, poisonous substances, compressed gases, explosives etc)

**Hazardous activities: Working underground, Flight cabin crew, crew on river/sea faring vessels, manual work at heights (line layers, window cleaners etc), Working with high voltage, working with high heat or high pressure gases, Manual labourers/workers, driving commercial heavy vehicles.

V. ADDITIONAL MEDICAL INFORMATION:

If answers to Q2 and Q8 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								

At the time of renewal, if the Policyholder chooses to migrate from 'Pratham' Plan to 'Uttam' Plan, Pre-existing condition related to Cancer, Heart, Stroke, & Major Organ/ Bone Marrow Transplant that were declared at the time of enrolment in 'Pratham' Plan and accepted by Us will receive continuity benefits on pre-existing disease waiting period.

A fresh waiting period will be applied on other pre-existing conditions and specific waiting periods from the Inception date of 'Uttam' Plan, which were not covered under 'Pratham' Plan.

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)

VI. PREVIOUS INSURANCE DETAILS:

Please 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 exclusions by any insurance company?
							Claim Number	Claimed Amount	Ailment	%	Amount	
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

VII. Current Insurance Details

In the unfortunate event of claim, the below information will facilitate Us, in case you have chosen Us as a Primary insurer to coordinate with other insurers to ensure the hassle free settlement of your claim as per the applicable policy terms and conditions.

Please fill the following details with respect to health indemnity insurance policies(s) currently with any other insurance company?

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							
Insured 6							
Insured 7							
Insured 8							

For active policies, please attach policy copies.
Insured wise information required with all the above information in 'Current Insurance Details'.

VIII. PAYMENT DETAILS*:

Premium Paid by : <First> <Middle> <Last> Relationship to Proposer : _____

Premium Amount : _____ in Words _____

Signature : _____

Payment Option: Cheque ☐ Demand Draft ☐ Pay Order ☐ Credit Card ☐ Debit Card ☐ Cash^ ☐

^For Cash Payments of ₹ 50,000 and above PAN Number is Mandatory

For Cheque / DD / Credit Card/ Debit Card/ PO/ Others (Please specify)_____(Payable in favour of "ManipalCigna Health Insurance Company Limited" – Proposal form No._____)

Instrument / Transaction Number : _____ Instrument/Transaction Date: D D M M Y Y Y Y

Instrument /Transaction Amount : _____

Bank Name : _____

Payment to be collected only from Proposers Card/Bank Account

IX. 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: D D M M Y Y Y Y

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. 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.

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

Date: D D M M Y 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)

XI. 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: D D M M Y 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)

XII. ADVISOR / INTERMEDIARY DECLARATION*:

I_____(Full name)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: D D M M Y Y Y Y **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 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 published prospectuses or tables of the insurer.
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.

ManipalCigna Sarvah _ Pratham | Proposal Form | UIN: MCIHLIP25035V012425 | URN: 2024/SRV-PR/V1.01 | October 2024

ACKNOWLEDGEMENT: (Tear Off)

Received from Ms / Mrs / Mr

a sum of ₹ _____ through Cash/Cheque/DD/Credit Card/Debit Card No. _____ against your proposal for _____ Policy.

Signature of ManipalCigna official / Intermediary: Date:

ManipalCigna official / Intermediary Name:

Time: Place:

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.