

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. C

Ref. B

MANIPALCIGNA SUPER TOP UP PROPOSAL FORM

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

Name of the Employee: _____

(Applicable only if Proposer or any Insured person under the policy is employee of: ManipalCigna, Promoter group/Group entity of the Promoter group/ Promoter of the Promoter group/ Group entity/ Group entity of the Group entity 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. <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 is the Payor:	<input type="checkbox"/>
Date of Birth*	: DD MM YYYY	Marital Status*	: Married <input type="checkbox"/> Single <input type="checkbox"/> Others <input type="checkbox"/>		
Name*(as in bank account):	F I R S T N A M E * M I D D L E N A M E S U R N A M E *				
Permanent Address*: (As per the KYC proof submitted):	Landmark: _____				
	City*:	Town (District):	Pin Code*:		
	State*:	Gram Panchayat:			
Correspondence Address*: If same as above, please tick here <input type="checkbox"/>	Landmark: _____				
	City* :	Town (District):	Pin Code*:		
	State*:	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

VID Number (Please mention only last four digits of your Aadhaar^{^^} or VID):

CKYC number : EIA number:

PEP or relative of PEP:

Family Physician Details:

Name : F I R S T N A M E M I D D L E N A M E S U R N A M E

Contact number : Email id:

Address :

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

Name* : F I R S T N A M E * M I D D L E N A M E S U R N A M E *

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 at : Hrs

(Must be on or later than instrument date/ premium payment date)

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

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*	Deductible*	Sum Insured*	Insured Address If Different From Proposer	If PEP/ Relatives of PEP^ (Y / N)	C-KYC number
1														
2														
3														
4														
5														
6														
7														
8														

^ 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>

All insured Indian national and Indian residents? Yes 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

Plan Type* : Individual <input type="checkbox"/> Floater <input type="checkbox"/>	Portability: Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes portability form to be completed and attached)	Migration: Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes migration form to be completed and attached)
Deductible (INR in Lacs)		Sum Insured (INR in Lacs)
₹3 <input type="checkbox"/> ₹3.5 <input type="checkbox"/>		₹3 <input type="checkbox"/>
₹3 <input type="checkbox"/> ₹3.5 <input type="checkbox"/> ₹4 <input type="checkbox"/> ₹4.5 <input type="checkbox"/> ₹5 <input type="checkbox"/> ₹5.5 <input type="checkbox"/>		₹4 <input type="checkbox"/>
₹3 <input type="checkbox"/> ₹3.5 <input type="checkbox"/> ₹4 <input type="checkbox"/> ₹4.5 <input type="checkbox"/> ₹5 <input type="checkbox"/> ₹5.5 <input type="checkbox"/>		₹5 <input type="checkbox"/>
₹3 <input type="checkbox"/> ₹3.5 <input type="checkbox"/> ₹4 <input type="checkbox"/> ₹4.5 <input type="checkbox"/> ₹5 <input type="checkbox"/> ₹5.5 <input type="checkbox"/>		₹6 <input type="checkbox"/>
₹3 <input type="checkbox"/> ₹3.5 <input type="checkbox"/> ₹4 <input type="checkbox"/> ₹4.5 <input type="checkbox"/> ₹5 <input type="checkbox"/> ₹5.5 <input type="checkbox"/>		₹8 <input type="checkbox"/>
₹3 <input type="checkbox"/> ₹3.5 <input type="checkbox"/> ₹4 <input type="checkbox"/> ₹4.5 <input type="checkbox"/> ₹5 <input type="checkbox"/> ₹5.5 <input type="checkbox"/> ₹7.5 <input type="checkbox"/> ₹10 <input type="checkbox"/>		₹10 <input type="checkbox"/>
₹3 <input type="checkbox"/> ₹3.5 <input type="checkbox"/> ₹4 <input type="checkbox"/> ₹4.5 <input type="checkbox"/> ₹5 <input type="checkbox"/> ₹5.5 <input type="checkbox"/> ₹7.5 <input type="checkbox"/> ₹10 <input type="checkbox"/>		₹15 <input type="checkbox"/>
₹3 <input type="checkbox"/> ₹3.5 <input type="checkbox"/> ₹4 <input type="checkbox"/> ₹4.5 <input type="checkbox"/> ₹5 <input type="checkbox"/> ₹5.5 <input type="checkbox"/> ₹7.5 <input type="checkbox"/> ₹10 <input type="checkbox"/>		₹20 <input type="checkbox"/>
₹3 <input type="checkbox"/> ₹3.5 <input type="checkbox"/> ₹4 <input type="checkbox"/> ₹4.5 <input type="checkbox"/> ₹5 <input type="checkbox"/> ₹5.5 <input type="checkbox"/> ₹7.5 <input type="checkbox"/> ₹10 <input type="checkbox"/>		₹30 <input type="checkbox"/>
<input type="checkbox"/> ManipalCigna Critical Illness Add On Cover		

Guaranteed Continuity on deductible (Available for insured person of Age < 55 years)

Reduction in Pre-existing disease waiting period

ManipalCigna Health 360 [UIN: MCIHLIA23023V012223]

ManipalCigna Health 360 - OPD
(Opt any one of the Packages below and Sum Insured)

<input type="checkbox"/> Package 1	<input type="checkbox"/> Package 2	<input type="checkbox"/> Package 3
<input type="checkbox"/> ₹5,000	<input type="checkbox"/> ₹10,000 <input type="checkbox"/> ₹50,000	<input type="checkbox"/> ₹20,000 <input type="checkbox"/> ₹60,000
<input type="checkbox"/> ₹10,000	<input type="checkbox"/> ₹15,000 <input type="checkbox"/> ₹60,000	<input type="checkbox"/> ₹25,000 <input type="checkbox"/> ₹70,000
<input type="checkbox"/> ₹15,000	<input type="checkbox"/> ₹20,000 <input type="checkbox"/> ₹70,000	<input type="checkbox"/> ₹30,000 <input type="checkbox"/> ₹80,000
<input type="checkbox"/> ₹20,000	<input type="checkbox"/> ₹25,000 <input type="checkbox"/> ₹80,000	<input type="checkbox"/> ₹40,000 <input type="checkbox"/> ₹90,000
	<input type="checkbox"/> ₹30,000 <input type="checkbox"/> ₹90,000	<input type="checkbox"/> ₹50,000 <input type="checkbox"/> ₹100,000
	<input type="checkbox"/> ₹40,000 <input type="checkbox"/> ₹100,000	

Applicable Discounts:
Tick if applicable

- Worksite marketing discount** Worksite Code: Employee id:
- Family discount:** 10% discount on the premium is applicable for covering 2 or more members under a Policy. (Applicable only with cover on individual basis)
- Long term discount:** 7.5% and 10% discount on the premium applicable for a policy term of 2 and 3 years respectively. (Applicable only with Single premium payment mode)
- Online Renewal discount:** Yes No (Discount of 3% on the premium from next renewal, if the premium is received through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card)

Premium payment mode: Monthly^ Quarterly Half yearly Yearly Single

^2 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)

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 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 Intestinal Lung Diseases or Pneumoconiosis or Emphysema.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
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.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
i	Diabetes Mellitus	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
ii	Hypertension	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
iii	High Cholesterol	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
iv	Thyroid disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
v	Heart and Lung disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
vi	Digestive system disorders (Stomach and related organs)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
vii	Brain, nerve and Psychiatric (Mental) disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
viii	Other Endocrine (Hormonal) disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
ix	Bone, joints and muscle disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
x	Ear, nose, eye and throat disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
xi	Genito-urinary and Gynaecological disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
xii	Blood and related disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
xiii	Skin disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
xiv	Any other condition / illness / disorder / surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Habits 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
A	Smoke	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	Since how long does the applicant smoke								
a	<=20 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	>20 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	Tobacco	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	How many Pan masala / gutka packets does the applicant has in a day								
a	1-3 packets/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	4-6 packets/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	>6 packets/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C	Alcohol	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	How frequently does the applicant consume alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a	1-3 days/ week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	3-6 days / week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For Critical Illness Add On Cover		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q6	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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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 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. Medicaclaim, 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												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 2												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 3												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 4												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 5												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 6												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 7												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 8												<input type="checkbox"/> YES <input type="checkbox"/> 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							

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 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:

Instrument /Transaction Amount : _____

Bank Name : _____

Payment to be collected only from Proposers Card/Bank Account

