

POLICY DETAILS: Name of Product:

*Policy No.:

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 Date:

D	D	M	M	Y	Y	Y	Y
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POLICY HOLDER 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
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- Please fill the form in BLOCK LETTERS
- All the details marked* are mandatory
- Put a (✓) mark wherever
- Please use a separate Form for changes in more than One Policy and Single policy with multiple Insured
- Any alteration in form need to be counter signed by the policy holder

CHANGE IN NAME

Note: Any change requested in Name will be incorporated for all your policies with us

1. Women who wish to change their name/surname post marriage, are requested to forward a copy of the Marriage Certificate
2. For all other requests with significant name change, a copy of the gazetted notification is required.
3. In case of change in name on account of minor corrections, documentary evidence by way (Driving License / PAN Card / Election Card / Passport copy / Aadhaar Card / Any other Valid Government Proof) needs to be submitted. ☐ Policy Holder Or ☐ Insured

From

To

*Document Submitted ☐ Gazetted Notification ☐ Driving License ☐ PAN
☐ Election Card ☐ Aadhaar Card ☐ Others (Please Specify) _____

CHANGE IN DATE OF BIRTH

☐ Policy Holder
 Or
 ☐ Insured

Note: Any change requested in Date of Birth will be incorporated for all your policies with us

From

 To

*Reason for Change:

*Document Submitted:
 ☐ PAN Card
 ☐ Passport
 ☐ Driving License
 ☐ Others (Please Specify):

*Claim Settled (If Any):
 ☐ Yes
 ☐ No
 *Claim Pending (If Any)
 ☐ Yes
 ☐ No

CHANGE IN OCCUPATION (FOR INSURED ONLY)

[illegible]**CHANGE IN ADDRESS (FOR POLICY HOLDER ONLY)**

Note: Any change requested in Address will be incorporated for all your policies with us Permanent

Address*:

City*: Town (District):

State*: Pin Code*:

*Document Submitted: ☐ Passport ☐ Driving License ☐ Leave and License Agreement
☐ Bank Statement ☐ Others (Please Specify):

Correspondence:

Address*:

City*: Town (District):

State*: Pin Code*:

*Document Submitted: ☐ Passport ☐ Driving License ☐ Leave and License Agreement
☐ Bank Statement ☐ Others (Please Specify):

For further details, regarding Your current Zone of Cover, please refer to your Policy Wordings.

Change in zone (applicable only to ProHelath Insurance and ProHealth Prime)

☐ Policy Holder Or ☐ Insured

Name:*

FIRSTNAME

MIDDLENAME

SURNAME

Current Zone:

City:

State:

Pin Code:

Zone:

New Zone:

City:

State:

Pin Code:

Zone:

*Reason for Change in Zone:

All future correspondence or communication will be sent on updated address

CHANGE IN CONTACT DETAILS (FOR POLICY HOLDER ONLY)

Note:

Any change requested in Contact Details will be incorporated for all your policies with us Residence:

Mobile:

E Mail ID 1:

E Mail ID 2:

CHANGE OF NOMINEE (First Nominee Details)

Note:

You may register or update up to four (4) nominees under this policy.

Nominee Name

Salutation*

First Name*

Middle Name

Last Name*

Age*

Contact Details

Mobile*

Email *

Relationship with Proposer*

Share%*

Address

Communication Address

Address 1*

Address 2

Landmark

Pincode*

City

District

State

Gram Panchayat

Permanent Address

Address 1*

Address 2

Landmark

Pincode*

City

District

State

Gram Panchayat

Bank Details

Account Type

Bank Name*

Account No

IFSC*

Branch

MICR*

Bank City

Account holder*

CHANGE OF NOMINEE (Second Nominee Details)

Note: You may register or update up to four (4) nominees under this policy.

Nominee Name

Salutation*First Name*

F

I

R

S

T

N

A

M

E

Middle Name

M

I

D

D

L

E

N

A

M

E

Last Name*

S

U

R

N

A

M

E

Age*

Contact Details

Mobile*Email *Relationship with Proposer*Share%*

Address

Communication Address

Address 1*Address 2LandmarkPincode*CityDistrictStateGram Panchayat

Permanent Address

Address 1*Address 2LandmarkPincode*CityDistrictStateGram Panchayat

Bank Details

Account TypeBank Name*Account NoIFSC*BranchMICR*Bank CityAccount holder*

CHANGE OF NOMINEE (Third Nominee Details:)

Note: You may register or update up to four (4) nominees under this policy.

Nominee Name

Salutation*First Name*

F

I

R

S

T

N

A

M

E

Middle Name

M

I

D

D

L

E

N

A

M

E

Last Name*

S

U

R

N

A

M

E

Age*

Contact Details

Mobile*Email *Relationship with Proposer*Share%*

Address

Communication Address

Address 1*Address 2LandmarkPincode*CityDistrictStateGram Panchayat

ManipalCigna Health Insurance | Change Request Form | July 2026

Permanent Address

Address 1*

Address 2

Landmark

Pincode*

City

District

State

Gram Panchayat

Bank Details

Account Type

Bank Name*

Account No

IFSC*

Branch

MICR*

Bank City

Account holder*

Note: You may register or update up to four (4) nominees under this policy.

Salutation* First Name* F I R S T N A M E

Middle Name M I D D L E N A M E Last Name* S U R N A M E Age*

[illegible]

Address

Address 1*																								
Address 2																								
Landmark																								
Pincode*					City					District					State									
Gram Panchayat																								

Address 1*	
Address 2	
Landmark	
Pincode*	
City	
District	
State	
Gram Panchayat	

Account Type		Bank Name*	
Account No		IFSC*	
Branch		MICR*	
Account holder*		Bank City	

MEMBER DELETION

Sr. No.	Name (First*, Middle, Last*)	Gender* (Male/ Female/ Other)	DOB* (DD/MM/YYYY)	Relationship with Proposer*	*Claim Details		
					Yes/No	Claim No (If Yes)	Claim Status (If Yes)
1					Yes/No		
2					Yes/No		

HEALTHY REWARDS REDEMPTION (Applicable only to ProHealth Insurance and ProHealth Select (A))

I would like to convert my balance Healthy Rewards to Health Maintenance Benefit with effect from the date of this application.

a) Covert all eligible Healthy Rewards ☐ b) Convert only specific Healthy Rewards. Specify Points _____

CHANGES IN HEALTH CONDITION

Note: Any change requested in health condition will be incorporated for all your policies with us
Any alteration in the health or disease/ illness/ condition contracted or diagnosed before or after the date of proposal

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Name of Insured					
Name of Illness / Diseases suffering from or suffered in the past					

Date of first diagnosis:

Any other details (if operated/hospitalised/undergoing treatment/medication): _____

Reason for Change / Addition: _____

ANY OTHER CHANGE THAT YOU WISH TO INFORM US:

Policy Holder Or ☐ Insured

Name:*

(In case there is any alteration to the information you furnished at the time of proposing for cover, please provide the same below.)

Change From: _____

Change To: _____

Note:Your Policy has been issued based on the declarations on the Proposal Form filled at the time of taking the first Policy with us. The rates terms and conditions of the contract have been determined based on this information. Wherever there has been any material change to this information, We shall be entitled to modify or vary the terms of insurance and/ or premium, if necessary, accordingly. Any change in terms or premium will be communicated to You in writing and the Policy will be renewed after your specific consent to such changes.

POLICY HOLDER DECLARATION

"I hereby confirm having read and understood all the policy terms and conditions including those applicable to this request. I understand and accept that my request shall be processed in accordance with the terms and conditions of the policy."

***Signature /Thumb impression of Policy Holder:**

Date: _____

Place: _____

To be filled up if the policyholder has signed in vernacular language or affixed thumb impression.

I hereby declare that I have fully explained the contents of the request form and terms and conditions of the policy to the policy holder in the language understood to him / her and that the policy holder has affixed his / her the thumb impression / signed in vernacular after fully understanding the contents thereof.

*Signature of Witness:

Date:

DD

MM

YYYY

Place:

CUSTOMER ACKNOWLEDGEMENT SLIP



Policy No:

Type of Request Received:

Received By (ManipalCigna Health Insurance Executive): Date of Receipt:

DD

MM

YYYY

Signature of ManipalCigna Health Insurance Executive

Stamp

1800-102-4462

customercare@manipalcigna.com

www.manipalcigna.com