Toll Free No: XXXXX
Website: www.ManipalCigna.com
SMS: XXXXX

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/ Rural | Social: Yes ☐ No ☐	
Ops Tags:	Employee DMS Code: ManipalCigna Employee DMS Code	Partner Vertical Name: Partner Business Vertical Code	Partner Branch ID: Partner Branch Code
	Sub Intermediary Name: <<For POSP>>:	Sub Intermediary PAN: <<For POSP>>:	Other Details: <<For POSP>>:

Ref. A

Ref. B

Ref. C

MANIPALCIGNA PROHEALTH PRIME
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

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): FIRST NAME* MIDDLE NAME SURNAME*

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

Gram Panchayat:

Village Name: Village LGD Code:

City*: Town (District):

State*: Pin Code*:

Correspondence Address*: FIRST NAME* MIDDLE NAME SURNAME*

Same as above ☐

Gram Panchayat:

Village Name: Village LGD Code:

City*: Town (District):

State*: Pin Code*:

(The Proposer confirms that the residential address provided in the proposal form to the company is true and updated at all times. The Proposer agrees to promptly notify the Company of any change in address to ensure uninterrupted communication and claim processing.)

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 ☐

Note: Commercial communications (SMS/voice/WhatsApp) will be sent only pursuant to valid digital consent obtained/recorded underTRAI's Digital Consent Acquisition (DCA) framework and may be revoked at any time.Transactional/servicing messages needed to run your policy may continue as permitted by law.

Note: 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/

Do you prefer to receive all policy and related documents digitally? (via email/soft copy)?

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

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

Do you come under the below mentioned social sector classification? Yes ☐ No ☐

("Social Sector" includes Unorganised Sector,Informal Sector,Economically Vulnerable or Backward Classes and Other Categories of Persons, residing in both rural and urban areas.

(a) Unorganised sector" means an enterprise owned by individuals or self-employed workers and engaged in the production or sale of goods or providing service of any kind what soever,and where the enterprise employs workers; the number of such workers is less than ten.

(b)"Informal Sector" includes small scale, self-employed workers typically at a low level of organisation and technology, with the primary objective of generating employment and income, with heterogeneous activities like retail trade, transport, repair and maintenance, construction, personal and domestic services and manufacturing, with the work mostly labour intensive, having often unwritten and informal employer-employee relationship.

(c).Economically Vulnerable or Backward Classes" means persons who live below the poverty line.

(d).Other Categories of Persons" includes persons with disability as defined in Rights of Persons with Disabilities Act, 2016 and who may not be gainfully employed; and includes guardians who need insurance to protect spastic persons or persons with disability.)

Social Sector Card/Document:

(Please submit a copy of selected proof)

☐ BPL Card ☐ Jan Dhan Account Holder ☐ Pradhan Mantri Jan Arogya Yojna

☐ MNREGA Card ☐ DBT (Direct Benefit Transfer) Beneficiaries ☐ Pradhan Mantri Mudra Yojna

☐ eShram Card ☐ PM Kisan Sanman Yojana ☐ Any other document issued by State/Central Government Please specify:_____

☐ PM Vishwakarma Yojana ☐ PM Awas Yojana

Document Number*
(Please specify the selected document number) _____

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

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

Highest 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 /Nationality: ☐ Indian ☐ NRI If NRI, Please mention country _____

☐ OCI If OCI, Please mention country _____

☐ Others (Please specify) _____

Pan Card Number* :

Form 97* (only in case where PAN number is not available) Yes ☐ No ☐

Aadhaar number^^/ (VID number)

CKYC number: _____ EIA number: (Electronic Insurance Account Number) _____

Politically Exposed Person (PEP) or relative of PEP^: Yes ☐ No ☐

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.

^Politically Exposed Persons (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials
If PEP details are not provided, we will consider the same as "No".

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

ManipalCigna ProHealth Prime | Proposal Form | UIN: MCIHLIP27045V032627 | URN: 2026/PPRI/V2.03 | September 2026

II. Nominee Details*:

Is the Nominee same as Caregiver (if provided above)? Yes ☐ No ☐

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		☐ Same as above _____	☐ Same as above _____	☐ Same as above _____
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: _____	Name: _____	Name: _____
			Age#: _____	Age#: _____	Age#: _____
			Mobile No. : _____	Mobile No. : _____	Mobile No. : _____
			E-mail ID: _____	E-mail ID: _____	E-mail ID: _____
			Relationship with Nominee: _____	Relationship with Nominee: _____	Relationship with Nominee: _____

Note:

As per regulatory mandate, nomination details are mandatory to be provided by the customers.

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*

Policy Type ☐ 1 Year	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 PERSON 1	INSURED PERSON 2	INSURED PERSON 3	INSURED PERSON 4	INSURED PERSON 5
Name (First*, Middle, Last*)					
Gender*					
DOB*					
Relationship with Proposer*					
ABHA Number^^^					
Height* (Cms)					
Weight* (Kgs)					
Gainful Annual Income*(Only if Personal Accident Cover is opted) (Note: Gainful Annual Income (GAI) means income earned through lawful and regular means of employment, trade, profession, or business, which is verifiable and provides evidence of sustained earning capacity)					
Occupation/ Industry Type/ Nature of Job* (Only if Personal Accident Cover is opted)					
City*					
Deductible					
Base Sum Insured* (only for individual cover and multi-individual cover)					
Outpatient Expenses* (For Advantage Plan)					

Do you fall under the category of Differently Abled Persons? If Yes, please enclose Disability Certificate mentioning the Percentage of disability wherever applicable Please enter the Unique Disability ID (UDID) Number Specify the percentage of Impairment	☐ Yes ☐ No UDID Number _____ % of impairment _____	☐ Yes ☐ No UDID Number _____ % of impairment _____	☐ Yes ☐ No UDID Number _____ % of impairment _____	☐ Yes ☐ No UDID Number _____ % of impairment _____	☐ Yes ☐ No UDID Number _____ % of impairment _____
Address if different from Proposer (Address Line 1* & Line 2 / Gram Panchayat Village Name Village LGD Code _____ City */Town (District) /State*/ Pin Code*)					
If PEP/Relatives of PEP^	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
CKYC Number					

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

^^^ABHA is optional. If you wish, you may create it and share it with your consent for sharing of medical records and any other related information, as well as to enable ABDM linked services. Learn more/create at the official ABDM portal: https://healthid.ndhm.gov.in/register.

*Are all insured Indian National and Indian Residents? ☐ Yes ☐ No, if No please mention country_____

Plan Type* :	**Portability:**	**Migration:**
☐ Individual (Active Plan is available only on Individual/Multi-individual basis) ☐ Floater	☐ Yes ☐ No (If yes portability form to be completed and attached)	☐ Yes ☐ No (If yes portability form to be completed and attached)

	Protect	**Advantage**	**Active**
Base Sum Insured	☐ ₹ 3 Lacs ☐ ₹ 20 Lacs ☐ ₹ 4 Lacs ☐ ₹ 25 Lacs ☐ ₹ 5 Lacs ☐ ₹ 30 Lacs ☐ ₹ 7.5 Lacs ☐ ₹ 40 Lacs ☐ ₹ 10 Lacs ☐ ₹ 50 Lacs ☐ ₹ 12.5 Lacs ☐ ₹ 100 Lacs ☐ ₹ 15 Lacs	☐ ₹ 5 Lacs ☐ ₹ 25 Lacs ☐ ₹ 7.5 Lacs ☐ ₹ 30 Lacs ☐ ₹ 10 Lacs ☐ ₹ 40 Lacs ☐ ₹ 12.5Lacs ☐ ₹ 50 Lacs ☐ ₹ 15 Lacs ☐ ₹ 100 Lacs ☐ ₹ 20 Lacs	☐ ₹ 3 Lacs ☐ ₹ 20 Lacs ☐ ₹ 5 Lacs ☐ ₹ 25 Lacs ☐ ₹ 7.5 Lacs ☐ ₹ 30 Lacs ☐ ₹ 10 Lacs ☐ ₹ 40 Lacs ☐ ₹ 12.5Lacs ☐ ₹ 50 Lacs ☐ ₹ 15 Lacs ☐ ₹ 100 Lacs
Optional Deductible (Not available on opting Assure optional package under Protect Plan)	☐ ₹ 10,000 ☐ ₹ 25,000	Not Available	Not Available
Outpatient Expenses (OPD)	Not Available	☐ ₹ 20,000 ☐ ₹ 50,000 ☐ ₹ 30,000	Not Available

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 Packages

☐ Enhance Plus (applicable for Protect Plan) Or ☐ Assure (applicable for Base Sum Insured Rs 3 Lacs, 4 Lacs and 5 Lacs under Protect Plan)
☐ Enhance (applicable for Advantage Plan) Or ☐ Freedom (applicable for Protect and Advantage Plans)

Optional Covers

Protect	**Advantage**	**Active**
☐ Non-Medical Items ☐ Personal Accident Cover ☐ Cumulative Bonus Booster (applicable for Base SI Rs 5 Lacs and above) ☐ Infertility Cover (Available only on opting optional packages Enhance Plus under Protect Plan or Enhance under Advantage Plan applicable for Base SI>= Rs 7.5 Lacs) (The cover shall cease upon the eligible Insured Person attaining 60 years of age)		☐ Non-Medical Items ☐ Worldwide Accidental Emergency Hospitalization ☐ Waiver of Mandatory Co-payment ☐ Health Check Up (applicable for Adult only) as against the Condition Management Program ☐ Waiver of Disease Specific Sublimit

Protect	Advantage	Active
		☐ Cumulative Bonus 105% of Base SI per/ year max upto 200% 25% of Base SI per year / yr max upto 200% 50% of Base SI per year / yr max upto 200% 15% / yr upto no limit ☐ Modification of Pre & Post Hospitalisation days ☐ 60/90 days ☐ 60/180 days

Protect	Advantage	Active
☐ **ManipalCigna Critical Illness Add On Cover** 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.		Not Available
☐ **ManipalCigna Prime Plus** ☐ **Room Rent Modification** ☐ Any room; ICU Up to Sum Insured ☐ Twin Sharing AC room; ICU Up to Sum Insured ☐ **Surplus Benefit** ☐ (Applicable with Base Sum Insured 5 Lacs and above) ☐ **Supreme Bonus** (Applicable with Base Sum Insured 5 Lacs maximum Up to 50 Lacs) (Can be opted only if Cumulative Bonus Booster Optional Cover is not opted) ☐ **Premium Management Cover**		☐ **ManipalCigna Prime Plus** ☐ **Room Rent Modification** (Applicable with Base Sum Insured 5 Lacs and above) ☐ Any room; ICU Up to Sum Insured ☐ Twin Sharing AC room; ICU Up to Sum Insured ☐ **Deductible** ☐ ₹10,000 ☐ ₹2,00,000 ☐ ₹25,000 ☐ ₹3,00,000 ☐ ₹50,000 ☐ ₹4,00,000 ☐ ₹1,00,000 ☐ ₹5,00,000
☐ **Women Care** ☐ **Deductible** ☐ ₹50,000 ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000 ☐ ₹4,00,000 ☐ ₹5,00,000	Not Available	

☐ **Zone of Cover (Please tick against your Zone):**

☐ Zone I	☐ Zone II	☐ Zone III
	☐ I would like to upgrade to Zone 1 and waive off Zonal Co-payment	

Zone I:
Delhi & NCR.
Districts in Gujarat: Ahmedabad, Gandhinagar, Surat, Vadodara.
Districts in Maharashtra: Mumbai, Thane, Navi Mumbai.
Districts in Andhra Pradesh /Telangana: Hyderabad, Khammam, Kothagudem, Hanamkonda, Warangal.
Districts in Uttar Pradesh: Mathura, Jyotiba Fule Nagar (Amroha), Aligarh.
Districts in Punjab: Amritsar, Gurdaspur.
Others: Kolkata, Rewari, Jind, Jhunjhunu, Patna.

Zone II:
Rest of the Bihar State Districts in Andhra Pradesh / Telangana: Ananthapur, Bapatla, Gadwal, Guntur, Jagtial, Kamareddy, Karimnagar, Kurnool, Mahabubnagar, Mancherial, Medak, Nalgonda, Nellore, Nizamabad, Peddapalli, Rangareddy, Suryapet, Wanaparthy.
Districts in Punjab: Rupnagar (Ropar), Ludhiana, Fatehgarh Sahib, Mohali, Patiala.
Districts in Maharashtra: Ahmednagar, Akola, Beed, Buldhana, Jalna, Latur, Nashik, Palghar, Pune, Raigad.
Districts in Uttar Pradesh: Banda, Fatehpur, Kanpur.
Others: Chennai, Bangalore, Wayanad, Chandigarh, Panchkula, Bokaro, Dhanbad.

Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II
(Note - Some areas (pin-codes) that are in the immediate vicinity of the districts mentioned in the zone definition above are classified in the respective zones of those districts)
Default zone of cover will be based on Proposer's city-location pin code as mentioned in CKYC document.

Standing Instruction Discount

Do you want to avail Standing Instruction Discount?	☐ Yes ☐ No

Consent:

☐ I hereby authorize, e-mandate for future payments via Net-banking/Card/UPI

IV. Medical and Lifestyle Information*

Please note: Proposed Insured(s) under the product having a history of Diabetes and/or Hypertension for 25 years or more, shall not be eligible to buy this product.

	Medical questions	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Q1	Has any of the applicant 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 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 Interstitial Lung Diseases or Pneumoconiosis or Emphysema. (If Yes, tick against the disease)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
i	Cancer/Tumor/Lump	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
ii	Rheumatoid Arthritis / Ulcerative Colitis / Crohn's disease	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
iii	Chronic Liver Disease, Hepatitis B, Liver Cirrhosis	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
iv	Chronic Kidney Disease / Kidney failure	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
v	Diseases of the Brain - Stroke/Paralysis/Parkinsonism /Alzheimer's/ Multiple sclerosis/Brain Tumor/ Cerebral Palsy	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
vi	Diseases of Heart - Heart Failure/Heart Attack/Angina/Coronary Artery Disease/Ischemic Heart Disease	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
vii	Chronic diseases of the Lungs - Chronic Bronchitis/ Interstitial Lung Diseases/ Pneumoconiosis/ Emphysema	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ 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.	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
i	**Diabetes Mellitus**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	How does the applicant manage his/her diabetes / pre-diabetes?					
a	Insulin	☐	☐	☐	☐	☐
b	Oral diabetic medication	☐	☐	☐	☐	☐
c	No medicine	☐	☐	☐	☐	☐
d	Any other treatment	☐	☐	☐	☐	☐
2	How many medicines does the applicant take to manage his/her diabetes / pre-diabetes?					
a	No medicine	☐	☐	☐	☐	☐
b	One medicine	☐	☐	☐	☐	☐
c	Two medicines	☐	☐	☐	☐	☐
d	Three or more medicines	☐	☐	☐	☐	☐
3	When was the applicant first diagnosed with diabetes / pre-diabetes?					
a	1 - 5 years	☐	☐	☐	☐	☐
b	5 - 10 Years	☐	☐	☐	☐	☐
c	10 - 15 years	☐	☐	☐	☐	☐
d	More than 15 Years	☐	☐	☐	☐	☐
ii	**Hypertension**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	How does the applicant manage his/her Hypertension / High Blood Pressure?					
a	No medicine	☐	☐	☐	☐	☐
b	One medicine	☐	☐	☐	☐	☐
c	Two medicines	☐	☐	☐	☐	☐
d	Three or more medicines	☐	☐	☐	☐	☐
2	When was the applicant first diagnosed with Hypertension / High Blood Pressure					
a	1 - 5 years	☐	☐	☐	☐	☐
b	5 - 10 Years	☐	☐	☐	☐	☐
c	10 - 15 years	☐	☐	☐	☐	☐
d	More than 15 Years	☐	☐	☐	☐	☐

iii	**High Cholesterol**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Is any of the applicant under medication for high cholesterol / high triglycerides					
a	Yes	☐	☐	☐	☐	☐
b	No	☐	☐	☐	☐	☐
iv	**Thyroid disorders**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Which thyroid disorder is the applicant suffering from?					
a	Goitre	☐	☐	☐	☐	☐
b	Hyperthyroidism (high thyroid activity)	☐	☐	☐	☐	☐
c	Hypothyroidism (low thyroid activity)	☐	☐	☐	☐	☐
d	Other thyroid disorders	☐	☐	☐	☐	☐
e	Thyroid Nodule	☐	☐	☐	☐	☐
f	Thyroiditis	☐	☐	☐	☐	☐
g	Any other	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
v	**Heart and Lung disorders**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Asthma	☐	☐	☐	☐	☐
2	Tuberculosis	☐	☐	☐	☐	☐
3	Upper Respiratory Tract Infection	☐	☐	☐	☐	☐
4	Lower Respiratory Tract Infection	☐	☐	☐	☐	☐
5	Varicose veins	☐	☐	☐	☐	☐
6	DVT (Deep vein thrombosis)	☐	☐	☐	☐	☐
7	Syncope	☐	☐	☐	☐	☐
8	Hypotension (Low Blood Pressure)	☐	☐	☐	☐	☐
9	Varicocele	☐	☐	☐	☐	☐
10	Lung Abscess	☐	☐	☐	☐	☐
11	Allergic Bronchitis	☐	☐	☐	☐	☐
12	Any other heart and lung condition	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
vi	**Digestive system disorders (Stomach and related organs)**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Peptic ulcer (Ulcer in stomach or duodenum)	☐	☐	☐	☐	☐
2	Appendicitis	☐	☐	☐	☐	☐
3	Cholecystitis/Cholelithiasis (Gall Bladder stones)	☐	☐	☐	☐	☐
4	Hemorrhoids(Piles)	☐	☐	☐	☐	☐
5	Anal Fissure	☐	☐	☐	☐	☐
6	Anal Fistula	☐	☐	☐	☐	☐
7	Pancreatitis	☐	☐	☐	☐	☐
8	Umbilical Hernia (Hernia at navel)	☐	☐	☐	☐	☐
9	Inguinal Hernia (Hernia in groin)	☐	☐	☐	☐	☐
10	Irritable bowel syndrome	☐	☐	☐	☐	☐
11	Fatty liver	☐	☐	☐	☐	☐
12	Any other	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____

vii	**Brain, nerve and Psychiatric (Mental) disorders**	YES NO	YES NO	YES NO	YES NO	YES NO
1	Recurring or severe headaches / Migraine					
2	Febrile Convulsions					
3	Vertigo (Recurrent dizziness)					
4	Encephalitis					
5	Mental Retardation/ Delayed development					
6	Anxiety					
7	Depression					
8	Psychosis					
9	Any other psychological disorders					
10	Dementia (Memory loss)					
11	Attention deficit Disorder					
12	Any other	_____	_____	_____	_____	_____
viii	**Other Endocrine (Hormonal) disorders**	YES NO	YES NO	YES NO	YES NO	YES NO
1	Parathyroid gland disorders					
2	Adrenal Disorder					
3	Pituitary Disorders					
ix	**Bone, joints and muscle disorders**	YES NO	YES NO	YES NO	YES NO	YES NO
1	Gout / Hyperuricemia (high uric acid in blood)					
2	Osteoarthritisr					
3	Shoulder Dislocation					
4	Spondylitis / Spondylosis					
5	Osteoporosis					
6	Prolapse of Inter-vertebral disc (disc prolapse					
7	Total Knee Replacement					
8	Total Hip Replacement					
11	Any other	_____	_____	_____	_____	_____
x	**Ear, nose, eye and throat disorders**	YES NO	YES NO	YES NO	YES NO	YES NO
1	Otitis-media (middle ear infection)					
2	Hearing loss					
3	Nasal Polyp					
4	Sinusitis					
5	Deviated Nasal Septum					
6	Tonsillitis					
7	Pharyngitis (throat infection)					
8	Cataract					
9	Glaucoma					
10	Vocal Cord Nodule					
11	Any other	_____	_____	_____	_____	_____
xi	**Genito-urinary and Gynaecological disorders**	YES NO	YES NO	YES NO	YES NO	YES NO
1	Kidney / bladder stones					

2	Recurrent Urinary tract infection	☐	☐	☐	☐	☐
3	Stricture Urethra	☐	☐	☐	☐	☐
4	Cystitis/ Infection of urinary bladder	☐	☐	☐	☐	☐
5	Urinary incontinence	☐	☐	☐	☐	☐
6	Benign Hypertrophy of Prostate	☐	☐	☐	☐	☐
7	Hydrocele	☐	☐	☐	☐	☐
8	Torsion of testes	☐	☐	☐	☐	☐
9	Phimosis	☐	☐	☐	☐	☐
10	Breast lump / Cyst / abscess	☐	☐	☐	☐	☐
11	Ovarian cyst	☐	☐	☐	☐	☐
12	Endometriosis	☐	☐	☐	☐	☐
13	Fibroid Uterus	☐	☐	☐	☐	☐
14	Menstrual disorder / irregular or excessive bleeding	☐	☐	☐	☐	☐
15	Bartholin's abscess / cyst	☐	☐	☐	☐	☐
16	Vaginal prolapse	☐	☐	☐	☐	☐
17	Cervical polyp	☐	☐	☐	☐	☐
18	Any other	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
xii	**Blood and related disorders**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Anaemia	☐	☐	☐	☐	☐
2	Thalassaemia	☐	☐	☐	☐	☐
3	Sexually transmitted diseases	☐	☐	☐	☐	☐
4	HIV / AIDS (Acquired Immuno-deficiency syndrome)	☐	☐	☐	☐	☐
xiii	**Skin disorders**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Psoriasis	☐	☐	☐	☐	☐
2	Eczema	☐	☐	☐	☐	☐
3	Dermatitis	☐	☐	☐	☐	☐
4	Urticaria	☐	☐	☐	☐	☐
5	Vitiligo	☐	☐	☐	☐	☐
6	Cyst/ lump/ growth / polyp / tumour	☐	☐	☐	☐	☐
7	Any other	☐ _____ _____	☐ _____ _____	☐ _____ _____	☐ _____ _____	☐ _____ _____
xiv	**Any other condition / illness / disorder / surgery**	☐ YES ☐ NO _____	☐ YES ☐ NO _____	☐ YES ☐ NO _____	☐ YES ☐ NO _____	☐ YES ☐ NO _____
Q3	Has any of the applicants recommended to undergo or has undergone any pathologic or radiologic tests Blood tests, X-Ray/USG/Scan/ MRI 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 _____
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 _____

Habits and Lifestyle questions		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Q5	Does any of the insured/s chew tobacco/ smoke/ consume alcohol or use any recreational drugs? Please tick the relevant box(es) below	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
A	Smoke	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Since how long does the applicant smoke					
A	<=20 years	☐	☐	☐	☐	☐
B	>20 years	☐	☐	☐	☐	☐
B	Tobacco	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	How many Pan masala / gutka packets does the applicant has in a day					
A	1-3 packets/day	☐	☐	☐	☐	☐
B	4-6 packets/day	☐	☐	☐	☐	☐
C	>6 packets/day	☐	☐	☐	☐	☐
C	Alcohol	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	How frequently does the applicant consume alcohol					
A	1-3 days/ week	☐	☐	☐	☐	☐
B	1-3 days/ week	☐	☐	☐	☐	☐
C	Daily	☐	☐	☐	☐	☐
For ManipalCigna Critical Illness Add On Cover		**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**
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	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
For Personal Accident Cover (if Opted)		**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**
Q7	Does any proposed to be insured suffer from any terminal illness, seizure disorders or any disease/deformity affecting or restricting mobility, sight, hearing or speech?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q8	Does any proposed to be insured's occupation or nature of duties require them to be a part of armed forces, expose them to hazardous substances/chemicals## or hazardous activities**	☐ 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.
For Personal Accident Plus - Proof of earning status/income (illustrative): ITR/Form 16, recent salary slips, employer certificate, GST returns or audited financials (if required)

labourers/workers, driving commercial heavy vehicles.
For Personal Accident - Proof of earning status/income (illustrative): ITR/Form 16, recent salary slips, employer certificate, GST returns or audited financials(If required)

V. Additional Medical information

If answers to any of the Question from Q2 to Q5 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
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	Histo-Pathology Examination Report (only for surgical) - No abnormality, Malignancy/ borderline malignancy/ Tuberculosis					

Note: Basis the medical declarations provided above we may/may not warrant a pre-policy medical check-up. In cases where a pre-policy medical check-up has been undertaken by the proposed Insured Person(s) and the insurance policy is not issued or the proposal is not taken forward, the entire expenses incurred towards the pre-policy medical check-up shall be payable by the Proposer.

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				Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Policy No								
Type of Policy e.g. Mediclaim, PA, CI, Hospital Cash								
Insurer Name								
From Date								
To Date								
Sum Insured								
Claim Details	Claim Number	Claimed Amount	Ailment					
Cumulative Bonus Earned		%	Amount					
Coverage amount for maternity in existing policy[+]								
Coverage for Maternity benefit under existing policy (number of years)[+]								
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? (Y – Yes / N – No)				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[+]To be filled only if 'Maternity and Newborn Expenses' optional cover is opted

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 out 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	Base 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 'Previous/Current Insurance Details

VIII. Payment Details*:

Premium Paid by: FIRSTNAME* MIDDLENAME SURNAME*

Relationship to Proposer: _____ Premium Amount: _____ in Words_____

Signature: _____

Payment Option:

☐ Cheque	☐ Demand Draft	☐ Pay Order	☐ Credit Card
☐ Debit Card	☐ Cash	☐ BASBA$	

^For Cash Payments of ₹50,000 and above Pan Number is Mandatory
For Cheque / DD / Credit Card/ Debit Card/ PO/BASBA/ Others (Please specify) _____ (Payable in favour of "ManipalCigna Health Insurance Company Limited" – Proposal form No. _____)

$ ☐ I/We hereby give my/our explicit consent for debiting the insurance premium from my/our bank account.
Where the BASBA option is selected, I/We authorise the Insurance Company and/or the Bank, as applicable, to block or unblock funds in the bank account or UPI-linked account specified in the Proposal Form, and to transfer funds only upon acceptance of the insurance proposal by the Insurance Company
BASBA/ Bima-ASBA - Bima Applications Supported by Blocked Amount

Instrument / Transaction Number

Instrument/Transaction Date DD MM YYYY

Instrument /Transaction Amount

Bank Name

Payment to be collected only from Proposers Card/Bank Account.

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. Policy period will start from date of debit of requisite premium from the Proposer's card/ bank account. In case of ASBA transactions, Policy period will start from date of acceptance of the proposal irrespective of the debit from the account of the proposer.

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 Company Limited about any change in bank account details. I also hereby certify that the particulars URN: 2026/PPRI/V3.01 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 authorized to propose/declare on behalf of all the proposed 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 risk acceptance by the company.

I/We declare and consent to the company seeking medical information from any doctor or hospital who/which at anytime has attended on the person be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured/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 provide my/our explicit and informed consent to Company or its representatives to contact me and members insured under the Policy (including overriding my registration on NCPR/NDNC and/or under any extant TRAI regulations) and / or notify about the services being rendered by the Company

☐ I/We, hereby agree that the PAN details and other information provided by me/us in the proposal form maybe used by the Company or its authorized representatives to access/download/verify/register/ update my/our KYC documents on/from the CERSAI* CKYC portal for processing this application and for any servicing, claims and other requests. (*Central Registry of Securitisation and Asset Reconstruction and security Interest of India.) I hereby consent that I may receive information from Central KYC Registry through sms / email on the above registered number/email address related to this proposal / policy.

Further, I hereby provide my/our explicit and informed consent to and authorize ManipalCigna Health Insurance Company Limited ("Company") and its representatives to collect, use, share and disclose information including personal information and claim information of all members insured under the Policy ("Personal Information") provided by me, as per the privacy policy of the Company, for the sole purpose of servicing the policy. I also declare that I have the necessary authorization from all members insured under the Policy to collect/ process/ authorize sharing of all Personal Information with the insurance company, insurance intermediaries and associated service providers for sole purpose of insurance policy servicing

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 the Insurance Advisor/ Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer has explained the requirements in the proposal form and the terms and conditions of the Policy in the language understood by me. I have affixed my thumb impression/signature below after fully understanding the contents thereof.

Date: D D M M Y Y Y Y

Place:

Signature of Proposer/ Authorized Representative:_____

(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/Authorized 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 Propose r 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 favor 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 out or renew or continue an insurance in respect of any kind 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 insurers.

(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 ProHealth Prime | Proposal Form | UIN: MCIHLIP27045V032627 | URN: 2026/PPRI/V2.03 | September 2026

ACKNOWLEDGEMENT: (Tear Off)

Received from Ms / Mrs / Mr

a sum of ₹ _____through Cash/Cheque/DD/Credit Card/Debit Card No/BASBA/Others._____ against your proposal for_____

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 Policy 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 realized.

Should you choose to pay premium by Cash, you are advised to do so only at the nearest ManipalCigna branch or its authorized 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