

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:	Sub Intermediary PAN:	Other Details:

Ref. A

Ref. B

Ref. C

MANIPALCIGNA INFINIX
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 Employee Discount# please provide _____

Name of the Employee: _____ Employee ID: _____

#10% Employee Discount applicable only if the Proposer of this policy is a ManipalCigna employee at the time of buying (at inception) this policy

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*	DD MM YYYY	Marital Status*	: Married ☐ Single ☐ Others ☐	
Name*(as in bank account):	FIRSTNAME MIDDLENAME SURNAME			
Permanent Address*: (As per the KYC proof submitted):				
Gram Panchayat:				
Village Name:			Village LGD Code:	
City*:			Town (District):	
State*:			Pin Code*:	
Correspondence Address*: Same as Permanent Address provided above ☐				
Gram Panchayat:				
Village Name:			Village LGD Code:	
City*:			Town (District):	
State*:			Pin Code*:	

(The Proposer confirms that the correspondence address provided in the proposal form to the company is true and updated as on date. The Proposer agrees to promptly notify the Company of any change in address to ensure uninterrupted communication and claim adjudication and payouts.)

^APolitically 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”.

ManipalCigna INFINIX | UIN: MCIHLIP2704V012627 | URN: 2026/INFXXV1.01 | August 2026

II. 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	☐ Same as above else please mention _____	☐ Same as above else please mention _____	☐ Same as above else please mention _____
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	☐ 2 Year	☐ 3Year
Proposed Policy Period from (Must be on or later than instrument date/ premium payment date)	DD MM YYYY at 00:00 hours		
Policy Type	☐ Individual Policy (1A)	☐ Family Floater Policy (Applicable only for Infinix Now and Infinix Core)	
Plan Variant	☐ Infinix Now	☐ Infinix Core	☐ Infinix Active
Preferred Provider Network(PPN) package	☐ Classic package	☐ Premier package	☐ Premier Plus package
Link: https://www.manipalcigna.com/locate-us  (Kindly scan the QR Code to know more about hospitals under PPN package)	Note for Classic and Premier Package 1. Co-payment shall apply if treatment is availed in a hospital outside the opted package		
Base Sum Insured (₹) options for Infinix Now & Infinix Core	☐ ₹10Lac	☐ Unlimited	
	(Although the Base Sum Insured may be selected as Unlimited, certain benefits under this product are subject to specific sub-limits. Please refer to prospectus and policy wordings for details of benefits covered up to the Base Sum Insured and benefits applicable with sub-limits.)		
Base Sum Insured (₹) options for Infinix Active (The opted SI eligibility will be subject to Underwriting)	☐ ₹5Lac to 1Cr	Please specify opted amount: ₹ _____	
Premium Payment mode	☐ Single	☐ Accelerated	
	If accelerated, please choose the applicable monthly instalment option		
	☐ 3 instalments	☐ 6 instalments	☐ 9 instalments
	☐ 24 instalments	☐ 36 instalments	
	Note for Accelerated Premium payment mode: 1. Accelerated Instalments - The total premium shall be paid through equal monthly instalments starting from the first Policy month of the policy period and shall continue every month upto the selected instalment period. The Policyholder/Insured Person must pay the instalment premium every month as per the EMI option selected. 2. Payment of Instalment(s) in advance -The policyholder/insured person may choose to pay all remaining instalments for the policy period upfront at any time during the policy period; however, no discount or waiver on premium payment loading will be provided for such advance payment.		

IV. INSURED DETAILS*

(Max upto 8 insured members can be covered in a single policy)

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)					
City*					
Do you fall under the category of Differently Abled Persons?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, please enclose Disability Certificate mentioning the Percentage of disability wherever applicable Please enter the Unique Disability ID (UDID) Number	UDID Number _____	UDID Number _____	UDID Number _____	UDID Number _____	UDID Number _____
Specify the percentage of Impairment	% of impairment _____	% of impairment _____	% of impairment _____	% of impairment _____	% 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^^					

^^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>.

V. OPTIONAL COVERS AT INDIVIDUAL LEVEL

Particulars	INSURED PERSON 1	INSURED PERSON 2	INSURED PERSON 3	INSURED PERSON 4	INSURED PERSON 5
New Beginnings (Base benefit amount opted cannot be altered in subsequent renewals)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
	☐ No	☐ No	☐ No	☐ No	☐ No
	If yes, kindly select the applicable option				
	☐ ₹5,000 ☐ ₹10,000 ☐ ₹20,000				
Personal Accident Plus (Available for selection only with Infinix Now and Infinix Core)	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
	☐ No	☐ No	☐ No	☐ No	☐ No
	If yes, kindly select the applicable option				
	☐ Accidental Death only ☐ Permanent Disability (PTD + PPD) only ☐ Both Accidental Death & Permanent Disability (PTD + PPD) with a common benefit amount Coverage amount (range: ₹5Lac to ₹10Crores) Please specify opted coverage amount ₹ _____				

Notes

1. New Beginnings may be opted by any Insured Person aged 18 years or above. For policies where-in both the spouses have opted for new-beginnings: In such cases the claim payout for a particular delivery/termination event will be paid by using only one benefit amount of either the husband or wife but not both. The highest available benefit amount will be used for the claim.

2. A male Insured Person aged 18 years or above may opt for New Beginnings for his spouse irrespective whether she is covered under this policy or not. Valid spouse proof shall be required at claim stage. The waiting period served by the male member will apply for his spouse's coverage.

3. Personal Accident Plus: Min. Age at Entry- 18 years and Max. Age at Entry – 65 years

Consent for Good Health Declaration for Personal Accident Plus

☐ "I hereby declare that none of the proposed insured members has ever suffered or is currently suffering from any seizure disorder, physical or mental impairment, infirmity, deformity, or any condition affecting mobility, sight, hearing, or speech, nor any illness that may influence health or work capacity till date.

Furthermore, I confirm that as of today none of the proposed members' occupations involve:

- Manual labour,
- Handling hazardous substances or chemicals (such as inflammables or combustibles, carcinogens, allergens, irritants, asphyxiants, toxic gases, pesticides, poisonous substances, compressed gases, explosives, etc.),
- Hazardous activities (such as working underground, at heights, with high voltage, high heat, or high-pressure gases, as flight or marine crew, or armed forces, Supervisors involved in work in underground mining, tunnelling, manufacturing, construction, dealing with heavy machines, Workers involved in mining, construction, mineral processing, any manufacturing work, plant operation work in chemical plants, plant operation work in rubber, textile plants, Technicians working in High electrical voltage and related occupation),
- Adventure sports, Instructors or related occupation, Acrobats, professional sportsmen, Jockey, Film Stuntman, Racing Drivers and circus professionals, Workers involved in wildlife, forestry & fisheries,
- Drivers of heavy trucks and vehicles (eg. JCB), Drivers of commercial vehicles, Aviation, Railways, Shipping crew & related workers, Armed forces, Police, State & Central reserve police, Homeguards,
- All self employed, businessmen in hazardous business,
- Working with heavy vehicles"

VII. Optional Covers at Policy Level*:

1	Health Check-up ^s	☐ Yes	☐ No
2	High-End Diagnostic Tests ^s (Available only if Unlimited Base Sum Insured is opted)	☐ Yes	☐ No
3	Air Ambulance	☐ Yes	☐ No
4	Annual Aggregate Deductible (Total opted amount must be breached once every policy year)	☐ Yes	☐ No
		If yes, kindly select the applicable option	
		☐ ₹1Lac	☐ ₹2Lac
		☐ ₹4Lac	☐ ₹5Lac
5	One-time Aggregate Deductible ^s (Total opted amount must be breached only once while this benefit is in force)	☐ Yes	☐ No
		If yes, kindly select the applicable option	
		☐ ₹25,000	☐ ₹50,000
		☐ ₹1,00,000	
6	Room Rent Modification	☐ Yes	☐ No
		If yes, kindly select the applicable option	
		☐ Any Room excluding Suite & above (available only with unlimited Sum Insured Option in Infinix Now and Infinix Core)	
		☐ Any Room (available only with unlimited Sum Insured Option in Infinix Now and Infinix Core)	
		☐ Upto Twin Sharing AC Room	
7	Coverage for Non-Medical Expenses & Durable Medical Equipment	☐ Yes	☐ No
8	Reduction of Waiting Period (Available for selection only with Infinix Core)	☐ Reduction of Pre-existing disease and Specified disease/procedure waiting period from 36 months (default inbuilt) to 24 months	
9	QuickAccess (Available for selection only with Infinix Core)	☐ Coverage for listed PED from 30 days; Coverage for Specified diseases/procedures after a waiting period of 24 months	

Note:

- Annual Aggregate Deductible, One-time Aggregate Deductible and ManipalCigna GMC Discount options are mutually exclusive.
- Health Check-up shall be available to all insured persons aged 18 Years or above at the start of a Policy year.
- Reduction of Waiting Period option is available only at inception once opted cannot be opted out.
- One-time Aggregate Deductible cannot be opted out once selected.
- The ^s symbol means that the optional cover is not Available for Infinix Active
- Reduction of Waiting Period and QuickAccess are mutually exclusive.

Consent for Good Health Declaration for High End Diagnostic Test/ Room Rent Modification/ Coverage for Non-Medical Expenses and Durable Medical Equipment	
☐ I hereby confirm that none of the proposed to be insured members have ever been diagnosed and/or treated, or had any consultation or investigation related to Cancer/tumor, Kidney, Heart or Lungs, Liver, Brain or Neurological, musculoskeletal, or blood disorder till date. Additionally, I confirm that none of the proposed members have sustained any major burns or accidents with any active implant or disability till date."	
NRI /OCI Discount	
(Available for selection only with Infinix Now and Infinix Core. Not Available for Infinix Active)	
(Do you want to avail NRI/OCI Discount? (This option is available only if all proposed insured person(s) under the policy are NRIs/OCIs and residing overseas).	☐ Yes ☐ No
Notes Pertaining to NRI/OCI Discount: a. For continuity of NRI/OCI discount, at each renewal you have to further declare that all Insured Person(s) are still NRIs and residing overseas. b. If at renewal, NRI/OCI status of even a single Insured Person in the policy is not attained, NRI/OCI discount shall not be provided to the entire policy. c. The eligibility for OCI to attain this discount is that they must be residing in India for less than 182 days in immediate preceding financial year.	
ManipalCigna GMC Discount	
Do any of the Insured members hold an active Group Medclaim policy with ManipalCigna?	☐ Yes ☐ No
If yes, please provide the below details	
If Covered under Group Employer Employee Policy (Refer details mentioned in your Health Card)	Master Policy Number: _____ Employee ID: _____
If Covered under Group Non-Employer Employee Policy (Refer details mentioned in your Policy Certificate)	Certificate of Insurance [COI] Number: _____
Standing Instruction Discount (Available for selection only with Infinix Now and Infinix Core. Not Available for Infinix Active and for policies if premium is paid in instalments)	
Do you want to avail Standing Instruction Discount?	☐ Yes ☐ No
Consent: ☐ I hereby authorize, e-mandate for future payments via Net-banking/Card/UPI	
Loyalty Discount (Available for selection only with Infinix Now and Infinix Core. Not Available for Infinix Active)	
"If you already are a policyholder in an active retail health indemnity policy with us and buy this policy as the Policyholder, you can avail a one-time 5% discount on the premium"	
☐ Yes	☐ No
If yes, please provide the below details - Policy Number: _____ (Refer details mentioned in your Health Card)	

VIII. Medical and Lifestyle Information*

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; operated, hospitalized, investigated, under treatment for 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
ii	Hypertension	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
iii	High Cholesterol	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
iv	Thyroid disorders	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Goitre	☐	☐	☐	☐	☐
2	Hyperthyroidism (high thyroid activity)	☐	☐	☐	☐	☐
3	Hypothyroidism (low thyroid activity)	☐	☐	☐	☐	☐
4	Thyroid Nodule	☐	☐	☐	☐	☐
5	Thyroiditis	☐	☐	☐	☐	☐
6	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	☐	☐	☐	☐	☐
4	Cholelithiasis (Gall Bladder stones)	☐	☐	☐	☐	☐
5	Hemorrhoids(Piles)	☐	☐	☐	☐	☐
6	Anal Fissure	☐	☐	☐	☐	☐
7	Anal Fistula	☐	☐	☐	☐	☐
8	Pancreatitis	☐	☐	☐	☐	☐
9	Hernia	☐	☐	☐	☐	☐
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	Epilepsy	☐	☐	☐	☐	☐
3	Febrile Convulsions	☐	☐	☐	☐	☐
4	Vertigo (Recurrent dizziness)	☐	☐	☐	☐	☐
5	Encephalitis	☐	☐	☐	☐	☐
6	Mental Retardation/ Delayed development	☐	☐	☐	☐	☐
7	Anxiety	☐	☐	☐	☐	☐
8	Depression	☐	☐	☐	☐	☐
9	Psychosis	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐
4	Any other	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
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	Osteoarthritis	☐	☐	☐	☐	☐
3	Shoulder Dislocation	☐	☐	☐	☐	☐
4	Spondylitis / Spondylosis	☐	☐	☐	☐	☐

5	Osteoporosis	☐	☐	☐	☐	☐
6	Prolapse of Inter-vertebral disc (disc prolapse	☐	☐	☐	☐	☐
7	Total Knee Replacement	☐	☐	☐	☐	☐
8	Total Hip Replacement	☐	☐	☐	☐	☐
9	Back and neck problem, sprain, Sciatica, Spinal Disorder, Backache	☐	☐	☐	☐	☐
10	Any history of fracture in past?	☐	☐	☐	☐	☐
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	Are you suffering from Dimness/ Blurring of vision in absence of Cataract)	☐	☐	☐	☐	☐
10	Glaucoma	☐	☐	☐	☐	☐
11	Retinal Disorder	☐	☐	☐	☐	☐
12	Vocal Cord Nodule	☐	☐	☐	☐	☐
13	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 Disorders	☐	☐	☐	☐	☐
12	Endometriosis	☐	☐	☐	☐	☐
13	Fibroid Uterus	☐	☐	☐	☐	☐
14	Menstrual disorder / irregular or excessive bleeding	☐	☐	☐	☐	☐
15	Bartholin's abscess / cyst	☐	☐	☐	☐	☐
16	Uterus prolapse	☐	☐	☐	☐	☐
17	Cervical polyp	☐	☐	☐	☐	☐
18	Is insured person pregnant	☐	☐	☐	☐	☐
19	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)	☐	☐	☐	☐	☐
5	Any other	☐	☐	☐	☐	☐
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
1	Smoke- Cigarette or Bidies or Cigar	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
2	Tobacco	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
3	Alcohol	☐ 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
##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)						

IX. 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)

X. Previous Insurance Details:

Please fill in the following details of the health insurance policies(s) currently held with Us or with 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. Mediciam, PA, CI, Hospital Cash						
Insurer Name						
From Date						
To Date						
Base 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 'New Beginnings' optional cover is opted

XI. 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 'Current Insurance Details'.

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

☐ /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.

XIII. 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*:[illegible]

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 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.
- Signature of 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)

Date:

D	D	M	M	Y	Y	Y	Y
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XIV. 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 to 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 CERSA* 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
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[illegible]

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)

XV. 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
---	---	---	---

[illegible]

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)

XVI. 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 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 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
---	---	---	---

[illegible]

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.



ACKNOWLEDGEMENT: (Tear Off)

[illegible]

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

Signature of ManipalCigna official / Intermediary: _____ Date: _____

ManipalCigna official / Intermediary Name:	
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Time:

 Place:

Note: Neither the submission of a completed proposal for insurance or any payment for any Policy sought obliges 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

Note:

1. Proposal form shall be used for multiple partners/channels/platforms and it shall be customized as per the specific requirement/nature of the partners/channels/platforms.
2. Every customized version of the proposal form will have a new version of the URN.
3. Post issuance of the Policy, we will provide a filled copy of this application form to the Policyholder, which may include, sections where the customer has provided any information/details.
4. You are advised to read this document in conjunction with the Policy Wordings of this product for indepth details on product benefits and better understanding of your policy.