Proposal Form No.: _____

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

ManipalCigna Health Insurance

Photograph of Insured 5	Photograph of Insured 6	Photograph of Insured 7	Photograph of Insured 8
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 ACCIDENT SHIELD
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/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. ☐ 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): 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):

State*: Pin Code*:

Gram Panchayat:

Village Name: Village LGD Code:

Correspondence Address*: If same as above, please tick here ☐

Landmark:

City* : Town (District):

State*: Pin Code*:

Gram Panchayat:

Village Name: Village LGD Code:

Email Address* : Address 1 Address 2

ManipalCigna Accident Shield | UIN: MCIPAIP24083V012324 | URN: 2026/ACSH/V1.04 | September 2026

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

Social Sector Card/Document:

(Please submit a copy of selected proof)

- BPL Card
- MNREGA Card
- eShram Card
- PM Vishwakarma Yojana
- Jan Dhan Account Holder
- DBT (Direct Benefit Transfer) Beneficiaries
- PM Kisan Sanman Yojana
- PM Awas Yojana
- Pradhan Mantri Jan Arogya Yojna
- Pradhan Mantri Mudra Yojna
- Any other document issued by State/Central Government

Please specify_____

Document Number*: _____

(Please specify the selected document number)

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

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

Aadhaar number^^/ (VID number) :

CKYC number : EIA number:

PEP or relative of PEP:

Family Physician Details:

Name : FIRSTNAME MIDDLENAME SURNAME

Contact number : Email id:

Address :

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

Name* : FIRSTNAME* MIDDLENAME SURNAME*

Mobile number* : Relationship with Proposer:

Age (in Years) : Email id:

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

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

II. NOMINEE DETAILS*:

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

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.

III. POLICY/PLAN DETAILS*:

Plan Type*:	**Plan Name***	**Tenure***
Individual ☐	Classic ☐	1 Year ☐
Floater ☐	Plus ☐	2 Year ☐
In case of Family Option - Sum Insured for Non earning spouse will be limited to 60% of the Proposer and for Dependents (Children/Parents/In-laws) will be limited to 30% of the Proposer.	Pro ☐	3 Year ☐

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

NOTE: The marketing template of the below table shall be in line with our existing format wherein insured details are captured in row & remaining field against it.

Particulars	**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**
Name (First*, Middle, Last*)					
Gender*					
DOB*					
Relationship with Proposer*					
ABHA Number^^^					
Height* (Cms)					
Weight* (Kgs)					
Occupation/ Industry Type/ Nature of Job*					
City*					
Gainful Annual Income*					
Temporary Total Disablement					
Loss of employment SI (in ₹)- Options - 50k to 500k (in multiples of ₹ 10K) - The pay-out under Loss of Employment would be lowest of of Loss of Employment Sum Insured or current salary totalling to 3 months - At each Renewal Insured can change the Sum Insured under this cover basis the current salary					
Loan shield SI (in ₹) - Options - 1Lac to 1 Cr (in multiples of ₹ 10K) - The pay-out under Loan shield would be lowest of Loan Shield Sum Insured or actual outstanding Loan Amount. - At each Renewal Insured can change the Sum Insured under this cover basis the current outstanding Loan Amount.					
EMI shield SI (in ₹)-Options-50K to 500K (in multiples of ₹ 10K) - The pay-out under EMI Shield would be lowest of EMI Shield Sum Insured or 3 outstanding EMIs - At each Renewal Insured can change the Sum Insured basis the current outstanding EMI Amount.					
Child Welfare Benefit					
Sum Insured*					
Insured address if different from Proposer (Address, Gram Panchayat, City, Town (District), State/Pin Code)					
If PEP/Relatives of PEP ^ (Y / N)					
C-KYC number					

^ 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 Accident Shield: The minimum entry age under this policy is 18 years and maximum age at entry is 70 years. Dependent child/children shall be covered from the age of 5 years to 25 years.

1. **ManipalCigna Accident Shield**
Base cover includes Death, Permanent Total Disablement Permanent Partial Disablement, Funeral expenses, Repatriation of Mortal Remains as per opted plan.

OPTIONAL COVERS	
Classic & Plus	**Pro**
Burns benefit ☐	**Burns benefit** ☐
	Broken Bones Benefit ☐
Coma Benefit ☐	**Coma Benefit** ☐
Air Ambulance ☐	**Air Ambulance** ☐
Accidental Hospitalization ☐ **(This cover will be applicable for each insured members)** **₹ 5 Lac** ☐ **₹ 10 Lac** ☐ **₹ 15 Lac** ☐ **₹ 20 Lac** ☐ **₹ 25 Lac** ☐ **₹ 50 Lac** ☐	**Accidental Hospitalization** ☐ **(This cover will be applicable for each insured members)** **₹ 5 Lac** ☐ **₹ 10 Lac** ☐ **₹ 15 Lac** ☐ **₹ 20 Lac** ☐ **₹ 25 Lac** ☐ **₹ 50 Lac** ☐
	Adventure Sports Cover ☐
Medical Repatriation ☐	**Medical Repatriation** ☐

Note- 1) The benefits listed above are applicable to all insured members without any individual selection.
2) Member level optional covers are provided under insured section.

Applicable Discounts:

a. **Corporate discount-** Corporate discount- 5% of one-time discount for an employee who is working in any Public or Private Limited Companies (Submission of ID Card is mandatory)

Name of Company- ☐ HR Email ID- ☐

Employee ID- ☐ Employee Email ID- ☐

b. **Long Term policy discount** (Applicable only with Single premium payment mode)
   i. For Policy Period of 2 years - 7.5% on the total applicable premium
   ii. For Policy Period of 3 years - 10% on the total applicable premium

c. **Online Renewal Discount** of 3% discount on the renewal premium, if the renewal premium is received through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card)

d. ☐ **Worksite Marketing Discount** Worksite Code: ☐ Employee id: ☐

(Applicable only once at the time of inception)

Note - Only one of the following discounts can be opted - Worksite discount / Staff discount / Corporate discount

Maximum Discount in any policy year cannot exceed 25%.

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

^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)

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*:

ManipalCigna Accident Shield		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q1	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	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q2	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	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

##Hazardous substance/ chemicals: Substances, chemicals, mixtures which pose a significant risk to health and safety (Inflammable or combustibles, carcinogens, Allergens, Irritants, asphyxiants, toxic gases, pesticides, poisonous substances, compressed gases, explosives etc)
**Hazardous activities: Working underground, Flight cabin crew, crew on river/sea faring vessels, manual work at heights (line layers, window cleaners etc), Working with high voltage, working with high heat or high pressure gases, Manual labourers/workers, driving commercial heavy vehicles.

V. ADDITIONAL MEDICAL INFORMATION:

If answers to above questions 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/ CURRENT INSURANCE DETAILS:

Pease fill the following details with respect to health insurance policies(s) currently or held with the Company or any other insurance company (Individual or Group)?

Insured	Policy No.	Type of Policy e.g. Mediclaim, PA, CI, Hospital Cash	Insurer Name	From Date	To Date	Sum Insured	Claim Details			Cumulative Bonus Earned		Has any proposal for life, health, hospital daily cash or critical illness insurance on the life of the applicant ever been declined, postponed, loaded or been made subject to any special conditions such as exclusions by any insurance company?
							Claim Number	Claimed Amount	Ailment	%	Amount	
Insured 1												
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.

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 ☐ BASBA[$] ☐

For Cheque / DD / Credit Card/ Debit Card/ PO/ 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:

Instrument /Transaction Amount:

Bank Name:

Payment to be collected only from Proposers Card/Bank Account

IX. BANK ACCOUNT DETAILS*:

Mandatory details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account.

Please select any one of the below options as applicable.

☐ **Bank details as per premium cheque to be used for electronic fund transfer/refund..**

Bank account details as mentioned on the cheque being submitted along with the Proposal Form towards premium payment for insurance Policy should be used by the Company for electronic fund transfer as mode of payment.

Please fill the below table if the premium payment cheque does not have all the details required for electronic fund transfer.

Particulars of Bank Account*:

Account Number:	
IFSC / MICR Code:	
Name of the Bank:	
Account Holder Name:	

I agree and undertake to intimate in writing to ManipalCigna Health Insurance Co. Ltd about any change in bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

DISCLAIMER: ManipalCigna shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation- failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder.

Aforesaid NEFT transaction shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. ManipalCigna shall be indemnified against any loss/damage/claims caused to ManipalCigna in carrying out your aforesaid NEFT instructions.

Instructions:

- It is important for these electronic payment systems that the Policy Holder's name in the Policy must exactly match with the name in the Bank Account records/details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required.
- The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFS Code, which is applicable for NEFT only. (a number allotted to each participating banks branch) of the branch where the funds need to be transferred.
- Cancelled cheque should be attached along with the NEFT format.
- In case cancelled blank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required.
- NEFT Form needs to be complete in all respect.

Date: D D M M Y Y Y Y

Signature of Proposer *:_____

(A policyholder or prospect, who is a person with disability, may duly authorize a representative to give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)

X. DECLARATION & AUTHORISATION*:

I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/ or particulars given by me are true and complete in all respects to the best of my knowledge and that I/We am/are authorised to propose on behalf of these other persons.

I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.

I/We further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Government and/or Regulatory authority, including seeking and/or sharing of my medical data through ABHA.

☐ I hereby 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, I have fully explained the contents of the proposal form and terms and conditions of the Policy to the Proposer in the language understood to him/her and that the Proposer has affixed the thumb impression above after fully understanding the contents thereof.

Date: D D M M Y Y Y Y **Place:** _____

Signature of Proposer *: _____

(A policyholder or prospect, who is a person with disability, may duly authorize a representative to give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)

XII. ADVISOR / INTERMEDIARY DECLARATION*:

In my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein that will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I further confirm that I have explained the product features, terms and conditions to the prospect and the product opted is suitable to the needs of the customer.

I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the Policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

License No. / ID (Advisor/Corporate Agent/Broker/Relationship Officer): _____

Date: D D M M Y Y Y Y **Place:** _____ **Signature of Agent:**

Section 41 of Insurance Act 1938 (Prohibition of rebates):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

ACKNOWLEDGEMENT: (Tear Off)

Received from Ms / Mrs / Mr _____

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

Signature of ManipalCigna official / Intermediary: _____ Date:

ManipalCigna official / Intermediary Name: _____

Time: _____ Place: _____

Note: Neither the submission of a completed proposal for insurance or any payment for any Policy sought oblige the Company to agree to issue a Policy, which decision is and always shall be in the Company's sole and absolute discretion.

If ManipalCigna Health Insurance Company Limited accepts a proposal for insurance, it shall be subject to the board approved underwriting policy of the Company and the Policy terms and conditions of this product and the Company shall have no liability to make any payment if premium is not received by ManipalCigna Health Insurance Company Limited in full and in time, or is not realised.

Should you choose to pay premium by Cash, you are advised to do so only at the nearest ManipalCigna branch or its authorised collection points. Handing over cash to any Advisor/ Employee is solely at your own risk and the Company shall in no way be held responsible for any loss in this regard.

Insurance is a subject matter of solicitation.

ManipalCigna Accident Shield | UIN: MCIPAIP24083V012324 | URN: 2026/ACSH/V1.04 | September 2026