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: <<For POSP>>: Sub Intermediary PAN: <<For POSP>>: Other Details: <<For POSP>>:		

Ref. A

Ref. B

Ref. C

MANIPALCIGNA PRIME SENIOR
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*:

(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 ☐

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 ☐ _____

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 also 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
☐ 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

Document Number*: _____

(Please specify the selected document number)

Please specify_____

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: (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.

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 Age# Mobile No. E-mail ID Relationship with Nominee			

As per recent regulatory mandate, nomination details are mandatory to be provided by the customers. Please provide your nominee details urgently by emailing us at customercare@manipalcigna.com; contacting us on 1800-102-4462, or visit our nearest branch.

In the event of death of the Proposer, any payment due under the Policy shall become payable to the nominee, as per the 'Nomination' clause defined by the IRDAI and the receipt of the proceeds by such nominee would be sufficient discharge to the Company. For all other persons covered under the Policy, the Proposer will be the nominee.

#A Minor should not be declared as Appointee.

III. POLICY/PLAN DETAILS*:

Tenure*: 1 Year ☐ 2 Years ☐ 3 Years ☐	**Proposed Policy Period:** From 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)					
Occupation/ Industry Type/ Nature of Job*					
City*					
Deductible					
Co-Payment					
Base Sum Insured* (only for individual cover)					
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)					
C-KYC number					

^^^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.

Plan Type* : Individual ☐ Floater ☐ (2A - Husband and Wife)	**Portability:** Yes ☐ No ☐ (If yes portability form to be completed and attached)	**Migration:** Yes ☐ No ☐ (If yes migration form to be completed and attached)

Plan	**Classic**	**Elite**
Sum Insured	☐ 3 Lacs ☐ 5 Lacs ☐ 7.5 Lacs ☐ 10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs ☐ 50 Lacs	☐ 5 Lacs ☐ 7.5 Lacs ☐ 10 Lacs ☐ 15 Lacs ☐ 20 Lacs ☐ 25 Lacs ☐ 50 Lacs
Optional Deductible	☐ 10,000 ☐ 25,000 ☐ 50,000 ☐ 1 Lac ☐ 2 Lacs ☐ 3 Lacs ☐ 4 Lacs ☐ 5 Lacs	☐ 10,000 ☐ 25,000 ☐ 50,000 ☐ 1 Lac ☐ 2 Lacs ☐ 3 Lacs ☐ 4 Lacs ☐ 5 Lacs
Optional Co-payment (Mandatory Co-payment in the base policy is 20%)	☐ 0% ☐ 10% ☐ 30%	☐ 0% ☐ 10% ☐ 30%

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 Covers

1. **Any room Upgrade**
   ☐ Yes ☐ No
2. **Reduction in PED Waiting Period**
   ☐ Yes ☐ No
3. **Premium Management (Optional Cover Available only with Classic Plan)**
   ☐ Yes ☐ No
4. **Restoration of Base Sum Insured (Optional Cover Available only with Classic Plan)**
   ☐ Yes ☐ No

Add-On Covers

1. **ManipalCigna Health 360-Shield Add On Cover [UIN: MCIHLIA23023V012223]**
   Yes ☐ No ☐
2. **ManipalCigna Health 360-OPD Add On Cover [UIN: MCIHLIA23023V012223]**

Package 1,

₹5,000 ☐ ₹10,000 ☐ ₹15,000 ☐ ₹20,000 ☐

or

Package 2,

₹10,00 ₹15,000 ☐ ₹20,000 ☐ ₹25,000 ☐ ₹30,000 ☐ ₹40,000 ☐
₹50,000 ₹60,000 ☐ ₹70,000 ☐ ₹80,000 ☐ ₹90,000 ☐ ₹1,00,000 ☐

Package 3,

₹20,000 ☐ ₹25,000 ☐ ₹30,000 ☐ ₹40,000 ☐ ₹50,000 ☐
₹60,000 ☐ ₹70,000 ☐ ₹80,000 ☐ ₹90,000 ☐ ₹1,00,000 ☐

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 ☐ I would like to upgrade Zone 3 to Zone 2 and waive off Zonal Co-payment of Zone 2

Zone I: Mumbai, Thane & Navi Mumbai, Gujarat, Kolkata and Delhi & NCR.(Faridabad, Gurugram, Nuh, Rohtak, Sonepat, Rewari, Jhajjhar , Panipat, Palwal, Bhiwani,Charkhi Dadri, Mahendragarh, Jind, Karnal, Meerut, Ghaziabad, Gautam Budh Nagar , Bulandshahr, Baghpat, Hapur, Shamli,Muzaffarnagar, Alwar & Bharatpur)

Zone II: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Pune.

Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II.

a) Persons paying Zone I premium can avail treatment all over India without any Zonal Co-pay
b) Persons paying Zone II premium.
   I) Can avail treatment in Zone II and Zone III without any Zonal Co-pay
   ii) Availing treatment in Zone I will have to bear 10% of each and every claim.
c) Person paying Zone III premium.
   i) Can avail treatment in Zone III, without any Zonal Co-pay.
   ii) Availing treatment in Zone II will have to bear 10% of each and every claim.
   iii) Availing treatment in Zone I will have to bear 20% of each and every claim.

Your default zone is based on the city mentioned in your correspondence address.

Note: 1. Deductible and Optional Co-payment are mutually exclusive.
2. Room Upgrade and Premium Management cannot be opted together.
3. In Classic Plan, Restoration can be opted only with a Base Sum Insured of ₹5 Lacs and above.

IV. MEDICAL AND LIFESTYLE INFORMATION*:

Medical questions		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Q1	Have you or any of the persons proposed for insurance, recommended to undergo any surgery in last 12 months - Except - the ailment list mentioned in Annexure 2* (Refer Annexure to Proposal for the ailment list in Annexure 2)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q2	Have you or any of the persons proposed for insurance, ever suffered or suffering from any of the following:					
i.	**Diabetes Mellitus** **If Yes, please share the below details:**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
a)	**When was the person proposed for insurance first diagnosed (Age at onset) with Diabetes Mellitus**	☐ <= 25 Years ☐ > 25 Years	☐ <= 25 Years ☐ > 25 Years	☐ <= 25 Years ☐ > 25 Years	☐ <= 25 Years ☐ > 25 Years	☐ <= 25 Years ☐ > 25 Years
b)	**Treatment taken for Diabetes Mellitus**	☐ Tablets ☐ Insulin ☐ Tablets+Insulin ☐ No Treatment/ Diet Control	☐ Tablets ☐ Insulin ☐ Tablets+Insulin ☐ No Treatment/ Diet Control	☐ Tablets ☐ Insulin ☐ Tablets+Insulin ☐ No Treatment/ Diet Control	☐ Tablets ☐ Insulin ☐ Tablets+Insulin ☐ No Treatment/ Diet Control	☐ Tablets ☐ Insulin ☐ Tablets+Insulin ☐ No Treatment/ Diet Control
c)	**HbA1c Reference Range in last 6 months**	☐ HbA1c <=10% ☐ HbA1c >10% ☐ Not Done	☐ HbA1c <=10% ☐ HbA1c >10% ☐ Not Done	☐ HbA1c <=10% ☐ HbA1c >10% ☐ Not Done	☐ HbA1c <=10% ☐ HbA1c >10% ☐ Not Done	☐ HbA1c <=10% ☐ HbA1c >10% ☐ Not Done
d)	**Blood Sugar Reference Range in last 6 months** (FBS: Fasting Blood Sugar)	☐ FBS <=300 mg/dl ☐ FBS >300 mg/dl	☐ FBS <=300 mg/dl ☐ FBS >300 mg/dl	☐ FBS <=300 mg/dl ☐ FBS >300 mg/dl	☐ FBS <=300 mg/dl ☐ FBS >300 mg/dl	☐ FBS <=300 mg/dl ☐ FBS >300 mg/dl
e)	**Blood Sugar Reference Range in last 6 months** (PPBS: Post Prandial Blood Sugar)	☐ PPBS <=350 mg/dl ☐ PPBS >350 mg/dl	☐ PPBS <=350 mg/dl ☐ PPBS >350 mg/dl	☐ PPBS <=350 mg/dl ☐ PPBS >350 mg/dl	☐ PPBS <=350 mg/dl ☐ PPBS >350 mg/dl	☐ PPBS <=350 mg/dl ☐ PPBS >350 mg/dl
f)	**Any complication/s related to Diabetes Mellitus**	☐ Eye (Retinopathies) ☐ Kidney Diseases ☐ Foot Ulcers ☐ Tingling/Numbness/ Loss of sensation ☐ Heart complains ☐ Any other complications (……) ☐ No Complication	☐ Eye (Retinopathies) ☐ Kidney Diseases ☐ Foot Ulcers ☐ Tingling/Numbness/ Loss of sensation ☐ Heart complains ☐ Any other complications (……) ☐ No Complication	☐ Eye (Retinopathies) ☐ Kidney Diseases ☐ Foot Ulcers ☐ Tingling/Numbness/ Loss of sensation ☐ Heart complains ☐ Any other complications (……) ☐ No Complication	☐ Eye (Retinopathies) ☐ Kidney Diseases ☐ Foot Ulcers ☐ Tingling/Numbness/ Loss of sensation ☐ Heart complains ☐ Any other complications (……) ☐ No Complication	☐ Eye (Retinopathies) ☐ Kidney Diseases ☐ Foot Ulcers ☐ Tingling/Numbness/ Loss of sensation ☐ Heart complains ☐ Any other complications (……) ☐ No Complication
ii.	**Hypertension** If Yes, please share the below details:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
a)	**When was the person proposed for insurance first diagnosed (Age at onset) with Hypertension**	☐ <= 25 Years ☐ > 25 Years	☐ <= 25 Years ☐ > 25 Years	☐ <= 25 Years ☐ > 25 Years	☐ <= 25 Years ☐ > 25 Years	☐ <= 25 Years ☐ > 25 Years
b)	**Person proposed for insurance is on**	☐ Tablets ☐ No Tablets	☐ Tablets ☐ No Tablets	☐ Tablets ☐ No Tablets	☐ Tablets ☐ No Tablets	☐ Tablets ☐ No Tablets
c)	**Blood Pressure Reference Range**	☐ BP<=120-160mmHg /80-100mmHg ☐ BP >160mmHg/> 100mmHg	☐ BP<=120-160mmHg /80-100mmHg ☐ BP >160mmHg/> 100mmHg	☐ BP<=120-160mmHg /80-100mmHg ☐ BP >160mmHg/> 100mmHg	☐ BP<=120-160mmHg /80-100mmHg ☐ BP >160mmHg/> 100mmHg	☐ BP<=120-160mmHg /80-100mmHg ☐ BP >160mmHg/> 100mmHg
d)	**Any complication/s related to Hypertension**	☐ Breathlessness ☐ Kidney Diseases ☐ Brain Haemorrhage ☐ Heart Disease ☐ Chest Discomfort ☐ Any other complications (……) ☐ No Complication	☐ Breathlessness ☐ Kidney Diseases ☐ Brain Haemorrhage ☐ Heart Disease ☐ Chest Discomfort ☐ Any other complications (……) ☐ No Complication	☐ Breathlessness ☐ Kidney Diseases ☐ Brain Haemorrhage ☐ Heart Disease ☐ Chest Discomfort ☐ Any other complications (……) ☐ No Complication	☐ Breathlessness ☐ Kidney Diseases ☐ Brain Haemorrhage ☐ Heart Disease ☐ Chest Discomfort ☐ Any other complications (……) ☐ No Complication	☐ Breathlessness ☐ Kidney Diseases ☐ Brain Haemorrhage ☐ Heart Disease ☐ Chest Discomfort ☐ Any other complications (……) ☐ No Complication
iii.	**Dyslipidaemia** **If Yes, please share the below details:**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
a)	**Reference Range for Total Cholesterol**	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300
b)	**Reference Range for Triglycerides**	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300
c)	**Reference Range for Low Density Lipids (LDL)**	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300	☐ Reference Range for Cholesterol ☐ <=300 ☐ >300
d)	**Ratio of Total Cholesterol / High Density Lipids**	☐ Reference Range for Low Density Lipids ☐ <=200 ☐ >200 ☐ Not Done	☐ Reference Range for Low Density Lipids ☐ <=200 ☐ >200 ☐ Not Done	☐ Reference Range for Low Density Lipids ☐ <=200 ☐ >200 ☐ Not Done	☐ Reference Range for Low Density Lipids ☐ <=200 ☐ >200 ☐ Not Done	☐ Reference Range for Low Density Lipids ☐ <=200 ☐ >200 ☐ Not Done

e)	Any complication/s related to Dyslipidaemia	☐ Breathlessness ☐ BMI >40 ☐ Heart Disease ☐ Chest Discomfort ☐ Any other complications (……) ☐ No Complication	☐ Breathlessness ☐ BMI >40 ☐ Heart Disease ☐ Chest Discomfort ☐ Any other complications (……) ☐ No Complication	☐ Breathlessness ☐ BMI >40 ☐ Heart Disease ☐ Chest Discomfort ☐ Any other complications (……) ☐ No Complication	☐ Breathlessness ☐ BMI >40 ☐ Heart Disease ☐ Chest Discomfort ☐ Any other complications (……) ☐ No Complication	☐ Breathlessness ☐ BMI >40 ☐ Heart Disease ☐ Chest Discomfort ☐ Any other complications (……) ☐ No Complication
iv.	Asthma If Yes, please share the below details:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
a)	Has the person proposed for insurance have taken treatment for Asthma	☐ Inhalers ☐ Oral Steroids ☐ No treatment	☐ Inhalers ☐ Oral Steroids ☐ No treatment	☐ Inhalers ☐ Oral Steroids ☐ No treatment	☐ Inhalers ☐ Oral Steroids ☐ No treatment	☐ Inhalers ☐ Oral Steroids ☐ No treatment
b)	When was the person proposed for insurance been admitted to hospitals related to Asthma for	☐ >1 Year ☐ <= 1 Year ☐ No Hospitalization	☐ >1 Year ☐ <= 1 Year ☐ No Hospitalization	☐ >1 Year ☐ <= 1 Year ☐ No Hospitalization	☐ >1 Year ☐ <= 1 Year ☐ No Hospitalization	☐ >1 Year ☐ <= 1 Year ☐ No Hospitalization
v.	Cataract If No, please share the below details:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
a)	Does the person proposed for insurance have any blurring of vision during day / night?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
b)	Does the person proposed for insurance have sensitivity to light & glare?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
vi.	Arthritis/Joint Pain If No, please share the below details:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
a)	Does the person proposed for insurance suffer from chronic leg/joint pain with restriction ofmovements and/or impact on daily routine activities?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
b)	Is the person proposed for insurance on pain killers/NSAIDs for chronic leg pain? (NSAIDs: Non-Steroidal Anti-Inflammatory Drugs)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
vii.	Tuberculosis Lung If Yes, please share the below details:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
a)	Since when the proposed insured is suffering from Tuberculosis Lung	☐ <= 2 Years ☐ >2 Years	☐ <= 2 Years ☐ >2 Years	☐ <= 2 Years ☐ >2 Years	☐ <= 2 Years ☐ >2 Years	☐ <= 2 Years ☐ >2 Years
b)	The treatment taken for Tuberculosis Lung has	☐ Completed ☐ Incomplete treatment ☐ Surgical treatment ☐ Ongoing treatment	☐ Completed ☐ Incomplete treatment ☐ Surgical treatment ☐ Ongoing treatment	☐ Completed ☐ Incomplete treatment ☐ Surgical treatment ☐ Ongoing treatment	☐ Completed ☐ Incomplete treatment ☐ Surgical treatment ☐ Ongoing treatment	☐ Completed ☐ Incomplete treatment ☐ Surgical treatment ☐ Ongoing treatment
c)	Any recurrence of sign, symptoms or disease?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
viii.	Hyperthyroid If Yes, please share the below details:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	Types of treatment taken for Hyperthyroid	☐ Tablets-Neo-mercazole, Thyroxine, Eltroxine ☐ Surgical ☐ Radio Iodine therapy	☐ Tablets-Neo-mercazole, Thyroxine, Eltroxine ☐ Surgical ☐ Radio Iodine therapy	☐ Tablets-Neo-mercazole, Thyroxine, Eltroxine ☐ Surgical ☐ Radio Iodine therapy	☐ Tablets-Neo-mercazole, Thyroxine, Eltroxine ☐ Surgical ☐ Radio Iodine therapy	☐ Tablets-Neo-mercazole, Thyroxine, Eltroxine ☐ Surgical ☐ Radio Iodine therapy
Q3 (a)	Have you or any of the persons proposed for insurance, diagnosed & undertreatment or under evaluation for any of the listed conditions:					
i.	Paralysis with neuro deficit/ Parkinson's / Alzheimer's	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
ii.	Any Chronic Kidney/Chronic Lung disease/ disorder	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
iii.	Chronic Liver Disease/Hepatitis B/Hepatitis C/Chronic Pancreatitis	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
iv.	Auto Immune diseases like Ankylosis, Rheumatoid Arthritis, Systemic Lupus Erythromatosis, Sjogren's	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
v	Cancer or Malignant Tumour or Lump/Malignant cyst	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
vi	Epilepsy	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
vii	Heart Diseases	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
viii	Extra Pulmonary Koch's	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q3 (b)	Have you or any of the persons proposed for insurance, diagnosed in past, treated & recovered and currently not on any treatment for:					
i.	Cancer/Tumour/Lump	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
ii.	Epilepsy	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
iii.	Heart Diseases or Peripheral Vascular conditions	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

iv.	Physical impairment/infirmity/deformity or any condition that may affect mobility/ sight/ hearing/ speech	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q4	Have you or any of the persons proposed for insurance ever suffered or currently suffering from or under continuous treatment/consultation or medication for any of the medical conditions for more than 6 months except Hypothyroid, Multi vitamins, Calcium supplement and those mentioned in Q2, Q3(a) and Q3(b)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q5	Any other condition / illness / disorder / surgery/accident/ any other information relating to your health that has not been prompted by the questions listed	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

I have disclosed all facts related to medical history on behalf of all insured members and I understand that failure to disclose all facts will result in claim rejection and / or policy cancellation.

V. PREVIOUS INSURANCE DETAILS:

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

Insured	Policy No.	Type of Policy e.g. 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												☐ YES ☐ NO
Insured 2												☐ YES ☐ NO
Insured 3												☐ YES ☐ NO
Insured 4												☐ YES ☐ NO
Insured 5												☐ YES ☐ NO

VI. 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'.

VII. 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: D D M M Y Y Y Y

Instrument /Transaction Amount : _____

Bank Name : _____

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

VIII. 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)

IX. 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 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)

X. 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 *: _____

(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. ADVISOR / INTERMEDIARY DECLARATION*:

I, _____ (Full Name) 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 out 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 prospectus 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.

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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 _____ 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.

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.