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

ManipalCigna Health Insurance

CHANGE REQUEST FORM

POLICY DETAILS – Name of Product : _____

*Policy No.: Date: D D M M Y Y Y Y

Policy Holder Name: F I R S T N A M E * M I D D L E N A M E S U R N A M E*

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

CHANGE IN NAME

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

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

From 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*

To 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*

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

CHANGE IN DATE OF BIRTH

☐ Policy Holder Or ☐ Insured

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

From D D M M Y Y Y Y To D D M M Y Y Y Y

*Reason for Change:

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

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

CHANGE IN OCCUPATION (FOR INSURED ONLY)

Name: F I R S T N A M E * M I D D L E N A M E S U R N A M E

*Occupation as declared in the Policy:

*Current Occupation:

CHANGE IN ADDRESS (FOR POLICY HOLDER ONLY)

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

Permanent Address*:

City*: Town (District):

State*: Pin Code*:

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

Correspondence:
Address*:

City*: Town (District):

State*: Pin Code*:

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

**Disclaimer - Your current zone is based on the City mentioned in your correspondence address in the Proposal form. In case change of your address involves change of City, the specified Zone based on your City will apply and premiums will be calculated accordingly. Please fill change in Zone section if the requested correspondence address falls under different Zone.*

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

CHANGE IN ZONE (Applicable to ProHealth Insurance and ProHealth Select)

☐ Policy Holder Or ☐ Insured

Name:* FIRST NAME * MIDDLE NAME SURNAME

Current Zone: City: Pin Code:

State: Zone:

New Zone: City: Pin Code:

State: Zone:

* Reason for Change in Zone: _____

All future correspondence or communication will be sent on updated address

CHANGE IN CONTACT DETAILS (FOR POLICY HOLDER ONLY)

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

Residence:

Mobile:

E Mail ID 1:

E Mail ID 2:

CHANGE OF NOMINEE

Name:* FIRST NAME * MIDDLE NAME SURNAME

Relationship with Policy Holder:

MEMBER DELETION

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

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

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

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

CHANGES IN HEALTH CONDITION

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

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

Date of first diagnosis: DD MM YYYY

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

_____

Reason for Change / Addition:

_____

_____

ANY OTHER CHANGE THAT YOU WISH TO INFORM US:

☐ Policy Holder Or ☐ Insured

Name:* FIRST NAME* MIDDLE NAME SURNAME

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

Change From: _____

Change To: _____

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

POLICY HOLDER DECLARATION

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

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

Date: DD MM YYYY

Place:

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

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

***Signature of Witness:**

Date: DD MM YYYY

Place:

CUSTOMER ACKNOWLEDGEMENT SLIP: (Tear Off)

ManipalCigna Health Insurance

Policy No:

Type of Request Received:

Received By (ManipalCigna Health Insurance Executive):

Date of Receipt: DD MM YYYY

Signature of ManipalCigna Health Insurance Executive

Stamp

1800-102-4462 **customercare@manipalcigna.com** **www.manipalcigna.com**