ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
CIN U66000MH2012PLC227948 | **IRDAI Reg. No.** 151 **Reg. Office:** 401/402, 4th Floor, Raheja Titanium, off. Western Express Highway, Goregaon (East), Mumbai- 400 063 | **Toll free number** – 1800-102-4462
Website address-www.manipalcigna.com | **E-mail:** servicesupport@manipalcigna.com

ManipalCigna Health Insurance

FREELOOK CANCELLATION REQUEST FORM

Any alteration in form need to be counter signed by the policy holder

POLICY DETAILS

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 *

Address:

City: State: Pin Code:

Phone No.:

Email ID:

REASON FOR FREELOOK

- [ ] Not Satisfied with the Terms and Conditions of the Policy
- [ ] Product features/benefits are different from what was requested or disclosed
- [ ] Others (Please Specify) _____

Documents Submitted: Policy Document ☐ Health Card ☐ Cancelled Cheque for Refund ☐

I hereby declare that I am the holder of the said policy. I understand that Freelook cancellation can be availed within 15 days of receipt of the policy document and payout under the policy shall be strictly in accordance with the policy terms and conditions. By availing this option the insurance contract and all rights/ titles and interest under the Policy shall stand terminated.

I request you to please process the cancellation of my policy under the Freelook option and refund the premium after adjusting the applicable charges (if any).

I hereby accept the free look value as per the policy contract and discharge ManipalCigna Health Insurance Company Ltd. in full satisfaction under the policy.

I understand that ManipalCigna Health Insurance Company Ltd reserves the right to reject the free look request if the conditions as mentioned policy contract/document are not fulfilled.

BANK DETAILS FOR FREELOOK REFUND VIA NEFT (For initial payment done by Cash/ Cheque/ Demand draft/ Direct debit)

Please furnish the details below along with copy of cancelled cheque.

Bank Name:

Bank Branch:

Bank Account No:

IFSC Code: MICR Code:

Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of name of the Bank, Branch name, Account number and IFSC code. If name of the policyholder is not printed on the cheque leaf please attach copy of the first page of the bank passbook also.

Please note: Freelook option is not available in case of renewal

Date: D D M M Y Y Y Y

Place: _____

Policy Holder Signature:

✂

CUSTOMER ACKNOWLEDGEMENT SLIP

ManipalCigna Health Insurance

Policy No:

Type of Request Received:

Received By (ManipalCigna Heallth Insurance Executive): Date of Receipt: D D M M Y Y Y Y

Signature of ManipalCigna Health Insurance Executive

Stamp

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

Apr19 onwards