

Proposal Form No.: \_\_\_\_\_

**FOR OFFICE USE**

Branch Name: _____	Branch Code: _____	Business Type: _____
Intermediary Name: _____	Intermediary Code: _____	Agent Code / Broker Code / CA Code _____
Urban/Rural: _____	Social: Yes <input type="checkbox"/> No <input type="checkbox"/>	

**MANIPALCIGNA LIFESTYLE PROTECTION GROUP POLICY**

**PROPOSAL FORM**



Note: The liability of the Company does not commence until this proposal is accepted by the Company and premium received.

**I. PROPOSER (CORPORATE) DETAILS:**

All invoices will be raised to the following address and addressed to the Principle contact person mentioned below

Proposer Name	:	First	Middle	Last
Principle Contact Person's Name:				
Types of Business:				
Correspondence (Present)* Address for all documentation: Block No./ Flat No.:		Floor No.:		
Building Name:				
Street Name :	Locality :	Landmark:		
City/ Village :	Pin Code:			
Permanent Address*:	Block No./ Flat No.:	Floor No.:		
Building Name:				
Street Name :	Locality :	Landmark:		
City/ Village :	Pin Code:			
Contact Number: Mobile*:		Office (Optional):		
Residence (Optional):				
Email Address*:	Address 1	Address 2		
PAN No./TAN No^^:				
Aadhaar number^^:				
Customer Goods & Service Tax Identification Number (if any):				
Period of Insurance: From:	DD	MM	YYYY	To: DD MM YYYY
Please state whether all eligible employees/families, members/families of the Group / Association / Institution / Corporate Body are proposed for Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Please state the Total Number of Employees/ Members to be covered (including families/ dependents wherever covered): _____				

\*-Mandatory ^^Please provide the details to enable us to serve you better.

**II. INSURED DETAILS:**

Please provide details of Insured Persons and of benefit and coverage required (Attach separate sheet with the following data elements)

Details	Insured 1	Insured 2
Unique Identification No. / Employee No. / Membership No.		
Name of Insured member		
Relationship to the proposer/member		
Designation/ Category/ position		
Date of Enrollment/ Joining		
Date of Birth (DD/MM/YYYY)		
Gender		
Pre-existing Diseases		
Email ID		
Mobile No.		
Sum Insured		
Optional Cover		
Optional Cover Sum Insured		
ABHA#		
Permanent Address* (AS per the KYC proof submitted):	Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) / State*/ Pin Code*	Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) / State*/ Pin Code*
Correspondence Address*:	<input type="checkbox"/> Same as above Address Line 1* & Line 2/ Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) /State*/ Pin Code*	<input type="checkbox"/> Same as above Address Line 1* & Line 2 / Gram Panchayat Village Name _____ Village LGD Code: _____ City */Town(District) /State*/ Pin Code*
Occupation*:	<input type="checkbox"/> Government Service <input type="checkbox"/> Private Sector <input type="checkbox"/> Self Employed <input type="checkbox"/> Others (please Specify _____)	<input type="checkbox"/> Government Service <input type="checkbox"/> Private Sector <input type="checkbox"/> Self Employed <input type="checkbox"/> Others (please Specify _____)
Do you come under the below-mentioned social sector classification? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>("Social Sector" includes Unorganised Sector, Informal Sector, Economically Vulnerable or Backward Classes and Other Categories of Persons, residing in both rural and urban areas.</p> <p>(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 whatsoever, and where the enterprise employs workers; the number of such workers is less than ten.</p> <p>(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.</p> <p>(c) "Economically Vulnerable or Backward Classes" means persons who live below the poverty line.</p> <p>(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.)</p>		
Social Sector Card/Document: (Please submit a copy of selected proof)	<input type="checkbox"/> BPL Card <input type="checkbox"/> MNREGA Card <input type="checkbox"/> eShram Card <input type="checkbox"/> PM Vishwakarma Yojana <input type="checkbox"/> Jan Dhan Account Holder <input type="checkbox"/> DBT (Direct Benefit Transfer) Beneficiaries <input type="checkbox"/> PM Kisan Sanman Yojana <input type="checkbox"/> PM Awas Yojana <input type="checkbox"/> Pradhan Mantri Jan Arogya Yojna <input type="checkbox"/> Pradhan Mantri Mudra Yojna <input type="checkbox"/> Any other document issued by State/Central Government Please specify _____ Document Number*: _____ (Please specify the selected document number)	<input type="checkbox"/> BPL Card <input type="checkbox"/> MNREGA Card <input type="checkbox"/> eShram Card <input type="checkbox"/> PM Vishwakarma Yojana <input type="checkbox"/> Jan Dhan Account Holder <input type="checkbox"/> DBT (Direct Benefit Transfer) Beneficiaries <input type="checkbox"/> PM Kisan Sanman Yojana <input type="checkbox"/> PM Awas Yojana <input type="checkbox"/> Pradhan Mantri Jan Arogya Yojna <input type="checkbox"/> Pradhan Mantri Mudra Yojna <input type="checkbox"/> Any other document issued by State/Central Government Please specify _____ Document Number*: _____ (Please specify the selected document number)

**Nominee Details\*:**

Is the Nominee same as Proposer (if provided above)? Yes  No.  If please provide Nominee details.

S. No.	Particulars	Nominee 1	Nominee 2	Nominee 3
1	Name			
2	Age			
3	Mobile No.			
4	Email ID			
5	Present 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 Relationship with Nominee			

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. PLAN DETAILS:

**Note:** Additional insurances (optional covers) can be purchased only in addition to a core plan and not separately. All elements can be chosen per group. In case of multiple plans/ sum insured requirements please mention the details against each member/ family in the attached format. Please select the required plan(s) (if multiple plans are required for different sets of employees, please fill the relevant plan in the Insured Details section):

<b>Group Personal Accident</b>	<b>Policy Term:</b> <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/> 4 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> (Short term policies)	
	<b>Cover Limit Basis:</b> <input type="checkbox"/> Sum Insured <input type="checkbox"/> Capital Sum Insured <small>(Highest Sum Insured selected under opted Basic Covers (AD, PTD, PPD) would be the Capital Sum Insured)</small>	
	<b>Basic Cover:</b>	<b>Sum Insured</b>
	<input type="checkbox"/> Accident Death Benefit	₹
	<input type="checkbox"/> Permanent Total Disablement Benefit (PTD)	₹
	<input type="checkbox"/> Permanent Partial Disablement Benefit (PPD)	₹
	<input type="checkbox"/> Temporary Total Disablement Benefit (TTD) (Can be opted only with one or more Basic Cover)	₹
	<b>Optional Covers:</b>	<b>Sum Insured</b>
	<input type="checkbox"/> Broken Bones Benefit	₹
	<input type="checkbox"/> Burns Benefit	₹
	<input type="checkbox"/> Coma Benefit	₹
	<input type="checkbox"/> Accidental Death Benefit (Common Carrier)	₹
	<input type="checkbox"/> Permanent Total Disablement Benefit (Common Carrier)	₹
	<input type="checkbox"/> Permanent Total Disablement Double Benefit	₹
	<input type="checkbox"/> Cost of Support Items Benefit	₹
	<input type="checkbox"/> Modification Allowance Benefit	₹
	<input type="checkbox"/> Rehabilitation Benefit	₹
	<input type="checkbox"/> Animal Attack Benefit	₹
	<input type="checkbox"/> Cost of Personal Protective Equipment (PPE) Damaged in the Accident Benefit	₹
	<input type="checkbox"/> Funeral Expenses Benefit	₹
	<input type="checkbox"/> Emergency Road Ambulance Benefit	₹
<input type="checkbox"/> Repatriation of Mortal Remains	₹	
<input type="checkbox"/> Dependent Children Benefit	₹	
<input type="checkbox"/> Spouse Benefit	₹	
<input type="checkbox"/> Dependant Parent Benefit	₹	
<input type="checkbox"/> Marriage Benefit for Dependent Children	₹	
<input type="checkbox"/> Education Fund Benefit	₹	
<input type="checkbox"/> Re-training Expenses Benefit	₹	
<input type="checkbox"/> Convalescence Benefit	₹	
<input type="checkbox"/> Hospital Cash Benefit	₹	
<input type="checkbox"/> Loss of Earning Benefit	₹	
<input type="checkbox"/> Family Counselling Benefit	₹	
<input type="checkbox"/> Family Transportation Allowance Benefit	₹	
<input type="checkbox"/> Medical Second Opinion	₹	
<input type="checkbox"/> Wellness Benefit	₹	
<input type="checkbox"/> Accidental Medical Expenses	₹	
<input type="checkbox"/> Out-Patient Treatment Allowance	₹	
<input type="checkbox"/> In- Patient Medical Expenses	₹	
<input type="checkbox"/> Emergency Evacuation	₹	
<input type="checkbox"/> Medical Repatriation	₹	
<input type="checkbox"/> Adventure Sports Benefit	₹	
<b>Group Critical illness:</b>	<b>Policy Term:</b> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/> 4 Years <input type="checkbox"/> 5 Years <input type="checkbox"/>	
Claim payout option: <input type="checkbox"/> Lumpsum	<b>Basic Cover:</b>	<b>Sum Insured</b>
	<input type="checkbox"/> Plan 1 (Critical illness 1- 36)	₹
	<input type="checkbox"/> Plan 2 (Critical illness 1- 30)	
	<input type="checkbox"/> Plan 3 (Critical illness 1- 15)	
	<input type="checkbox"/> Plan 4 (Critical illness 1- 11)	
	<input type="checkbox"/> Plan 5 (Critical illness 1- 6)	
	<input type="checkbox"/> Plan 6 Cancer of specific severity (Critical illness 1 Only)	
	<b>Optional Covers:</b>	<b>Sum Insured</b>
	<input type="checkbox"/> Survival Period Waiver Clause	
	<input type="checkbox"/> Emergency Road Ambulance Benefit	₹
	<input type="checkbox"/> Emergency Evacuation	₹
	<input type="checkbox"/> Medical Repatriation	₹
	<input type="checkbox"/> Marriage Benefit for Dependent Children	₹
	<input type="checkbox"/> Education Fund Benefit	₹
	<input type="checkbox"/> Convalescence Benefit	₹
<input type="checkbox"/> Hospital Cash Benefit	₹	

<input type="checkbox"/>	Rehabilitation Benefit	₹
<input type="checkbox"/>	Loss of Earning Benefit	₹
<input type="checkbox"/>	Family Counselling Benefit	₹
<input type="checkbox"/>	Family Transportation Allowance Benefit	₹
<input type="checkbox"/>	Medical Second Opinion	
<input type="checkbox"/>	Wellness Benefit	
<b>Sub-limits/Conditions etc (if any)</b>		
<< to be displayed as opted >>		

#### IV. DETAILS OF PREVIOUS INSURER(S) (If renewal):

Are your employees/ members at present insured under any Personal Accident/ Critical Illness Insurance? Yes  No

If 'Yes' Please provide the details insurer, type of policy with coverage & sum insured-(attach additional sheet if required)

Name of Insurer :

Policy Number :

Expiring Terms of cover :  (PA or CI or Health)

Period of Insurance :

Premium paid :

Claim details : (Please attach separate sheet providing complete details of claims with individual claim records)

Incurred Claims Ratio :

**Note:** Ensure that the information in this form material for assumption of risk is accurate and complete as inaccuracy or non-disclosure of the requested information or other material facts could preclude recovery of any claim under the policy

#### V. CURRENT INSURED DETAILS

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							

#### VI. PREMIUM PAYMENT DETAILS (Please provide the details of premium payment):

Premium Amount(₹):  Payment Option(pl. tick (√)):  Cheque  Demand Draft  Fund Transfer

Amount in Words:

Payment Frequency : Monthly  Quarterly  Half Yearly  Yearly  Single

**For Cheque / DD / PO** (Payable in favour of "ManipalCigna Health Insurance Company Limited")

Instrument Number:  Instrument Date:  Instrument Amount:

Bank Name:

Name of the Premium Payer:



## 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/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)

