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:** servicesupport@manipalcigna.com

Proposal Form No.: _____

FOR OFFICE USE

Branch Name: _____ Branch Code: _____ Business Type: Urban/ Social/ Rural

Intermediary Name: _____ Intermediary Code: Agent Code / Broker Code / CA Code

MANIPALCIGNA LIFESTYLE PROTECTION GROUP POLICY

PROPOSAL FORM

1. This form should be filled by the Corporate or any person authorised by the Corporate to sign on their behalf.
2. Please fill the form in BLOCK LETTERS.
3. Please submit the proposal form in original, photo copies will not be accepted by the Company.
4. Kindly contact the Company's Office for any doubt or clarification on the 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: D D M M Y Y Y Y To: D D M M Y Y Y Y

Please state whether all eligible employees/families, members/families of the Group / Association / Institution / Corporate Body are proposed for Insurance? Yes ☐ No ☐

Please state the Total Number of Employees/ Members to be covered (including families/ dependents wherever covered):

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

II. INSURED DETAILS:

Is the Address of insured different from that of the Proposer? ☐ YES ☐ NO
If Yes please provide:

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

Unique identification No./ Employee No./ Membership no.	Name of Insured member	Relationship of the family members with the Employee/ Member	Designation/ Category position	Date of Birth	Gender	Pre-existing Diseases	Email ID	Mobile No.	ABHA#	Sum Insured	Optional Cover	Optional Cover Sum Insured	Address & Gram Panchayat

Nominee Details*:

Is the Nominee same as Proposer (if provided above)? ☐ Yes ☐ No. If No, 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):

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

	☐ Rehabilitation Benefit	₹
	☐ Loss of Earning Benefit	₹
	☐ Family Counselling Benefit	₹
	☐ Family Transportation Allowance Benefit	₹
	☐ Medical Second Opinion	
	☐ Wellness Benefit	

Sub-limits/Conditions etc (if any)

<< 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:

VII. 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 on behalf of these other persons. I/We will maintain details of all the individual members covered, which shall also be made available to the insurance company as and when required.

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 any time 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.

☐ 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.
Also, 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:**

VIII. ADVISOR/INTERMEDIARY DECLARATION:

I, (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized 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 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 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 **Signature of Corporate Agent:**

Place:

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 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 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 penalty which may extend to ten lakh rupees.

INSURANCE IS A SUBJECT MATTER OF SOLICITATION

Note: Proposal form shall be used for group policy and it shall be customized as per the coverage and benefits offered under the product for the group as per their requirement.

BANK ACCOUNT DETAILS

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)

Annexure - A
KYC of Beneficial owners

Photograph of Insured 1	Photograph of Insured 2	Photograph of Insured 3	Photograph of Insured 4
Photograph of Insured 5	Photograph of Insured 6	Photograph of Insured 7	Photograph of Insured 8

Title* : Mr. ☐ Mrs. ☐ Ms. ☐ Gender*: Male ☐ Female ☐ Others ☐ Tick if Employer

Date of Birth* : D D M M Y Y Y Y Marital Status*: Married ☐ Single ☐ Others ☐ is the Payor: ☐

Beneficial Owner Name*: (as in bank account) FIRST* MIDDLE LAST*

Permanent Address : (As per the KYC proof submitted)
Address 1: Address 2:
Landmark:
City*: Town (District):
State*: Pin Code*:

Present Address* :
Address 1: Address 2:
Landmark:
City*: Town (District):
State*: Pin Code*:

Email Address* : Address 1: Address 2:

Telephone Number(s) : Mobile*: Residence (Optional):
Office(Optional):

Customer Goods & Service Tax Identification Number (if any):

Residential Status* : Indian ☐ NRI ☐ If NRI, Please mention country_____ Other (Please specify)

PAN Card Number* :

Form 60* (only in case where PAN number is not available): Yes ☐ No ☐

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

VID Number : (Please mention only last four digits of your Aadhaar or VID) Document Expiry date: D D M M Y Y Y Y

CKYC number : EIA number:

PEP or relative of PEP :