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

MANIPALCIGNA LIFETIME HEALTH

PORTABILITY FORM

PART I

1. PERSONAL DETAILS OF POLICYHOLDER/ INSURED:

Name of the Policy Holder/ Insured: FIRST MIDDLE SURNAME

Date of Birth: DD MM YYYY Age: (Years) (Months)

Email:

Address:

City: State:

Pin code:

2. DETAILS OF EXISTING INSURER:

i. Name of the Product:

ii. Sum Insured:

iii. Cumulative Bonus:

iv. Add-ons/riders taken:

v. Policy Number:

3. DETAILS OF THE PROPOSED INSURANCE:

i. Name of the product proposed/intend to take:

ii. Sum Insured Proposed:

iii. Whether Cumulative Bonus to be converted to an enhanced sum insured:

Reason(s) for Portability:

No. of family members to be included in the policy to be ported:

Enclosure: Photocopy of the existing policy documents

Date: DD MM YYYY

Signature of the Policy Holder

PART II

Whether the PED exclusions/ time bound exclusions have longer exclusion period than the existing policy: (Please indicate Yes/ No)

Yes No

If Yes, please give written consent to the declaration below:

I am aware that the waiting period for the following disease(s)/treatment(s) is days/ years more than the previous policy terms.
I hereby agree to observe the additional waiting period for the following disease(s)/ treatment(s)

Signature of Policy Holder

ManipalCigna Lifetime Health | UIN: MCIHLIP21559V012021 | January 2021

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MANIPALCIGNA LIFETIME HEALTH

PORTABILITY FORM (ANNEXURE)

SECTION A. PERSONAL DETAILS OF POLICYHOLDER/ INSURED:

i) Proposal Number

ii) Existing Insurance Details

1. Please indicate whether covered under: Group Policy ☐ Retail Policy ☐

2. Have you extended your current policy on short term basis? Yes ☐ No ☐

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Name								
Policy 1 DOJ (DD/MM/YYYY)								
Sum Insured								
Policy Type								
Cumulative Bonus								
Policy 2 DOJ (DD/MM/YYYY)								
Sum Insured								
Policy Type								
Cumulative Bonus								
Policy 3 DOJ (DD/MM/YYYY)								
Sum Insured								
Policy Type								
Cumulative Bonus								
Policy 4 DOJ (DD/MM/YYYY)								
Sum Insured								
Policy Type								
Cumulative Bonus								

DOJ - Date of joining D D M M Y Y Y Y Policy Type - Individual or Floater

iii) Pre- Existing Details

Pre-exiting details for Proposed Insured Persons (The below section is mandatory. Please fill in NIL where the section is not applicable.)

S.no	Name	PED declared	No. of years of Continuous Cover	Waiting period completed	Waiting period remaining
Insured 1					
Insured 2					
Insured 3					
Insured 4					
Insured 5					
Insured 6					
Insured 7					
Insured 8					

Documents to be provided:

1. Policy Schedule for the previous year(s) as available.
2. Renewal notice for the expiring policy

Acceptance of Portability is subject to the following

1. Application for Portability to ManipalCigna Health Insurance Company Limited is made at least 45 days before the policy renewal date of current insurance policy
2. Availability of relevant medical / Claim history from previous insurer.
3. Risk acceptance by Underwriting on evaluation of Proposal form or any Pre Policy Health Check up/ additional information.
4. Acceptance of revised offer (if any) must be provided within 7 days of intimation.
5. The company shall not be liable if the application is rejected due to non-adherence to the above guidelines.

Declarations

I understand that my application for portability is being processed and some details are being sought from my current Insurer prior to acceptance of proposed risk. In absence of receipt of the same before expiry of my existing policy, I authorize ManipalCigna Health Insurance Company Limited to process my application based on the information furnished along with the supporting documents provided herein. However, if any variance is subsequently found, ManipalCigna Health Insurance Company Limited shall at its discretion cancel/ modify my coverage through appropriate endorsement and/or take these into consideration while adjudicating any claims under this policy. I also understand that I can extend my existing policy with current insurer to ensure no break in coverage and shall intimate the same in writing to ManipalCigna Health Insurance Company Limited in case of no written communication regarding acceptance of proposed risk on or before expiry of my existing policy.

Date: D D M M Y Y Y Y

Signature of the Policy Holder

SECTION B: FOR MANIPALCIGNA OPERATIONS TEAM ONLY: The below section is mandatory

i. Details available from previous insurer: Yes ☐ No ☐

1. Claim history: Positive ☐ Negative ☐ 2. PED History: Positive ☐ Negative ☐

ii. Declaration in Proposal and Portability Form: Fill in Yes/ No as applicable

1. Medical Declarations: Positive ☐ Negative ☐ iii. PPMC Applicable for any person in the policy: Yes ☐ No ☐

Name of Customer for whom PPMC is applicable for the customer

Insured 1: _____

Insured 2: _____

Insured 3: _____

Insured 4: _____

Insured 5: _____

Insured 6: _____

Insured 7: _____

Insured 8: _____