Manipal Cigna
Health Insurance

MANIPALCIGNA HEALTH INSURANCE

Portability Form

PART I

1. Name of the Policy Holder/ Insured (s): FIRST MIDDLE SURNAME
2. Date of Birth: DD MM YYYY Age: (Years)
3. Address of the policyholder/insured:

City (District): State:

Pin code:

4. Details of existing insurer:
   - i. Name of the product:
   - ii. Sum Insured:
   - iii. Cumulative Bonus:
   - iv. Add-ons/riders taken:
   - v. Policy number:
5. 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:
6. Reason(s) for Portability:
7. 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

1.	Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy	(Please indicate Yes / No) **YES** ☐ **NO** ☐

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

Declaration

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 the Policy Holder