

NATIONAL AUTOMATED CLEARING HOUSE (NACH) MANDATE FORM

NACH option is a mandate to automatically pay your RENEWAL PREMIUMS ONLY by debiting the bank account specified by you, on / around the due date.

- PLEASE FILL THE FORM IN BLOCK LETTERS
- PLEASE FILL THE FORM WITH UTMOST CARE
- NO OVERWRITING/WHITENER LISAGE ALLOWED
- PLEASE STRIKE OUT PARTS, WHICH ARE NOT APPLICABLE AND WRITE 'N.A.' STROKES OF THE PEN, DOTS AND DASHES WILL NOT BE ACCEPTED AS REPLIES.

- Please read the terms & condition before completing this form.
- Please ensure that this mandate form reaches the company at least 30 days prior to the next premium due date.
- · Incase of applying for multiple policies, please fill separate mandate for each policy.
- In case of any modification/ revision in the policy terms or premium, if You do not agree with the revision, You may choose to opt out of the NACH facility, informing the insurer at least fifteen days prior to the premium

Authorization of customer to pay insurance premium of ManipalCigna Health insurance Company Limited, through NACH facility.

PARTICULARS OF THE POLICY HOLDER

Name of the Policyholder :											
Policy / Proposal Number :											
ANK ACCOUNT HOLDER'S RELATION	SHIP WITH POLICYHOLDER Ple	ease tick (√)									
Self Spouse	Parent/ Grand	Parent/ Grand Parent/Child Employer/Employee									
HUF Sole Proprietorship Con	Proprietorship	Concern of	Parent/0	Grandpa	arent/	Childre	en				
ote: f the Account holder is different from the c f joint account is NOT an either or survivo				submitte	d (if req	uired)				
lease tick (√)											
I have enclosed Cancelled Cheque v	ith Preprinted Account Holder Na	me & Bank Account	Number.								
I have enclosed Bank Account Statem	ent/ Pass Book Copy along with Ca	ancelled Cheque (only	if Account	Details a	re not P	reprir	nted on	the Can	celled C	heque)	
authorize ManipalCigna Health Insurance ayment of applicable premium for renewal any, and changes in statutory taxes applic	of the policy. I understand and agre										
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Manipal Cigna UMRN		<u> </u>					* D	D M	MY	/ Y \	
Health Insurance	nk Code ICIC0TREA00	3-			Utilii	ty Co	* D	D M	M Y	00194	/ Y
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ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited) IRDAI Registration Number 151. CIN: U66000MH2012PLC227948, Registered Address: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063. For queries and more information call tollfree number 1800-102-4462 or visit Website www.manipalcigna.com

DECLARATION FOR NACH

- 1. I hereby declare that the above information is correct and complete.
- 2. I acknowledge that I have read, understood and agree to be bound by the "Terms and Conditions" detailed in this form, as are currently in effect and as may be amended by ManipalCigna from time to time.
- 3. I wish to avail of the NACH facility and hereby express my unconditional consent to debit my above mentioned account through NACH for premiums of ManipalCigna Health Policy (including rider, if opted).
- 4. I understand and accept that the transaction will be effected into the policy on not exceeding two working days prior to the due date. If the transaction is delayed or not effected at all for reasons of incomplete or incorrect information, I shall not hold ManipalCigna responsible. Any charges/ penalty levied towards this facility shall not be payable by ManipalCigna. In case of failure of transaction or non-receipt of the renewal premium, the policy will not be renewed and it will terminate by the end of the grace period.
- 5. I authorize the above mentioned bank to debit my bank account if my NACH mandate is active and until I give a written request for cancellation of NACH.
- 6. I hereby authorize ManipalCigna, to enable the NACH facility for my premium payments and in the instance of NACH debit dishonor, to re-debit my account with the mentioned bank to recover the premium payable.
- 7. I understand and agree that the submission of this form does not mean that the request will be processed.
- 8. I understand that I will keep the policy in force to avail any benefit from ManipalCigna.
- 9. I understand that any payout under the policy by ManipalCigna shall be strictly in accordance with the policy terms and conditions. Also any payment shall be subject to realisation of the last renewal premium payment by ManipalCigna and subject to policy being inforce.
- 10. I also understand and agree that the Company reserves the right to use any alternative payment option.
- 11. I understand that I have an option to discontinue the premium payment through NACH facility by informing the insurer at least fifteen days prior to the premium due date.
- 12. If the policy is discontinued or terminated, NACH facility will be deactivated for the policy and no further premium would be debited from customer's registered account.

Application Date DDMMYYYY	Maximum Amount: ₹				
Accountholder's Signature	2nd Signature (in case of Joint account holder)	Policyholder's Signature (if Accountholder differs from policyholder)			
IN CASE SIGNATURE OF THE POLICYHOLDER IS IN Note: The below must be witnessed by someone other th standing whose identity can easily be established and this I (declare that I have explained the contents of the Debit form dictated by the Policyholder. The information filled in the Dhas affixed his/her signature on the Debit form after fully unwitness Details:	nan advisor/ employee of the company. The signature declaration should be made by him/her. name) holding (Identity Card type) in to the Policyholder in language and ebit form is the exact replication of the information provides	(Identity Card no.) hereby that I have read out to the Policyholder the information			
Name:					
ID Proof Type:	ID Proof Nu	mber:			
Signature of the Person making the Declaration					

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Instructions to fill mandate:

- 1. UMRN- To be left blank
- 2. Date in DD/MM/YYYY format
- 3. Sponsor Bank IFSC Code <<XXXXXXXXXX>> already printed
- 4. Utility Code Unique Code of the entity to whom the mandate is being given- Already printed
- 5. Name of the entity to whom the mandate is being given Already printed
- 6. Account type SB/ CA/ CC/ SB- NRE/ SB- NRO/ OTHER
- 7. Tick- Select your appropriate action
 - a. Create For New Mandate
 - b. Modify For Changes/ Amendment on existing mandate
 - c. Cancel For Cancelling the existing registered mandate
- 8. Customer's bank account number for debiting the account
- 9. Name of Bank

- 10. Customer bank's IFSC code or MICR code
- 11. Amount in Words
- 12. Amount in figures
- 13. Frequency at which the debit should happen
- 14. Whether the amount is fixed or variable
- 15. Reference 1 Policy no of the customer
- Reference 2 Any reference as requested by ManipalCigna Health Insurance Company Ltd
- 17. Customer's phone number with STD code
- 18. Customer's email id
- 19. Period for which debit mandate is valid. Kindly enter 'Start date'.
- 20. Signature of the accountholder
- 21. Name of the account holder

This is not a part of Proposal Form