ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
Registered & 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
CIN: U66000MH2012PLC227948

ManipalCigna Health Insurance

Proposal Form No.: _____

FOR OFFICE USE

Branch Name*: _____ Branch Code: _____ Business Type: Urban/ Social/ Rural
Intermediary Name: _____ Sourcing Department: _____ Intermediary Code*: Agent Code / Broker Code / CA Code
Ops Tags Employee DMS Code*: Manipal Cigna Employee DMS Code Partner Vertical Name*: Partner Business Vertical Code Partner Branch ID*: Partner Branch Code

MANIPALCIGNA PROHEALTH GROUP INSURANCE 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 :

Type of Business :

Correspondence (Present) Address* :
Block No./Flat No.: Floor No.: Building Name:
Street Name:
Locality:
Landmark: City/Village:
State: Pin code:

Permanent Address*
Block No./Flat No.: Floor No.: Building Name:
Street Name:
Locality:
Landmark: City/Village:
State: Pin code:

Contact Number : Landline: Mobile Number*:

Email Address*: :

PAN No/ TAN No.^^ :

Aadhaar No.^^ :

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): _____

Policy Type : ☐ Individual ☐ Family Floater ☐ Both

^^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 Enrollment/ Joining				
Date of Birth				
Gender				
Pre-existing Diseases				
Email ID				
Mobile No.				
Address & Gram Panchayat				
ABHA #				
Sum Insured				
Optional Cover				
Optional Cover Sub Option				
Optional Cover Sum Insured/Limit				

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):

Policy Tenure	☐ 1Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years
Base Sum Insured	₹ _____
Base Cover	**Option**
In-patient Hospitalization Expenses Cover	(Per Day Room rent expenses capped at 1% of Sum Insured and 2% of Sum Insured for ICU)
Day Care Treatment Cover	☐ No Day Care ☐ 10% of SI ☐ 25% of SI ☐ 50% of SI ☐ 100% of SI
Pre-Hospitalization/ Post Hospitalization Medical Expenses Cover	Pre-Hospitalization _____ Days Post-Hospitalization _____ Days 0-180 Days
Road Ambulance Cover	Sum insured: ₹ _____ ₹250 to ₹ 20,000
Domiciliary Treatment	
Donor Expenses	

Sr. No.	Optional Cover	Sum Insured	Sub Limit	Sub options
1	☐ **Disease Category Sub Limit**	NA	₹_____ The category limit options: From ₹ 1 Lac to ₹ 10 Lacs	NA
2	☐ **Maternity Expenses Cover**		₹_____ Sub-Limit Options available: From ₹ 10,000 to ₹ 5 Lacs	☐ Normal Delivery ____% ☐ Routine or elective C-section delivery ____% ☐ Complicated Pregnancy ____% ☐ Pre & Post Natal Expense ____% Limit for each option: From 1% - 100% of Maternity Sum Insured ☐ ₹ Cover for Surrogacy pregnancy
2 a	☐ **New Born Medical Expenses Cover** **(**The option is available with Maternity Expenses cover)		₹ _____ Sub Limit Options available: From ₹ 10,000 to ₹ 5 Lacs	Options available: ☐ To be part of maternity Sub Limit ☐ To be in addition to Sub Limit for maternity expenses cover
3	☐ **Out Patient Treatment Cover**	₹ _____ Sum Insured Options available: From ₹ 1,000 to ₹ 5 Lacs		Any one or combination of the following can be opted under the cover: ☐ Consultation ☐ Diagnostics ☐ Pharmacy ☐ Medical Aids ☐ AYUSH ☐ Dental ☐ Vision ☐ Physiotherapy ☐ Over the Counter (OTC) Medicines Cover limit Options: ☐ Up to opted Sum Insured ☐ Up to opted Sum Insured with _____ x% co-pay, where x can be 1-50%
4	☐ **Accumulate Cover**	₹ _____ Sum Insured Options available: ₹ 5,000 to Up to Sum Insured	NA	Any one or combination of the following can be opted under the cover: ☐ Consultation ☐ Diagnostics ☐ Pharmacy ☐ Medical Aids ☐ AYUSH ☐ Reasonable and Customary Charges towards payment of the Deductible/Co-Payment/non- payable of an In-patient Hospitalization Expenses claim or day care treatment claim Option to opt for Cumulative Bonus ☐ Yes ☐ No If yes, choose the Bonus Percentage _____% (Choose any number between 1% - 100%)
5	☐ **In-patient hospitalization – Percentage limit on room rent/ Amount limit on room rent/ Limit on room type (Category)**		**Per Day Room Rent as a percentage limit of Sum Insured:** **___%** 2% - 10% In case of ICU the limit will be two times Room rent OR **Per Day Room Rent amount limit:** ₹ _____ ₹ 500 to ₹ 10,000 In case of ICU the limit will be two times Room rent OR	

			Room type limit: ☐ Ward ☐ Up to Shared Room ☐ Up to Single Private Room ☐ Up to Deluxe Room ☐ Up to any room other than Suite ☐ No room type cap **ICU Limits with respect to room rent:** ☐ ____ 'x' times the room rent ☐ No Cap (Where 'x' can be any number or fraction max up to 10)	
6	☐ **Sub limit on Treatment/ Illness/ Disease/ Surgery/ Medical Condition**	NA	☐ Option 1 ☐ Option 2 ☐ Option 3	
7	☐ **Voluntary Co-pay for In-patient Hospitalization**	NA	NA	Voluntary Co-pay options: (Percentage of admissible claim amount) _____% 5% - 50%
8	☐ **Annual Aggregate Deductible**	NA	NA	Options available: ₹ 1,000 to ₹ 10 Lacs ₹ _____
9	☐ **Per Claim Deductible**	NA	NA	Options available: ₹ 500 to ₹ 10 Lacs ₹ _____
10	☐ **Corporate Deductible at a Group level**	NA	NA	Corporate deductible option: ₹ 2 Lacs to ₹ 100 Lacs ₹ _____
11	☐ **Maximum limit on Out of Pocket expenses** (Available only with the Voluntary Co-pay option)	NA	NA	Maximum limit on out of pocket expenses option: ₹ 5,000 to ₹ 10 Lacs ₹ _____
12	☐ **Directed Plan**	NA	NA	Directed plan options available: ☐ x% co pay on admissible claim amount within network ☐ x% co pay on admissible claim amount outside network ☐ x% co pay on admissible claim amount for non – Personal accident/Critical Illness and no co-pay for Personal accident/Critical Illness within network ☐ x% co pay on admissible claim amount for non - Personal accident/Critical Illness and no co-pay of Personal accident/Critical Illness out of network ☐ Only directed network x = _____% (Choose between 5% to 50%)
13	☐ **Reimbursement only cover**	NA	NA	NA
14 a	☐ **Hospital Daily Cash Benefit Cover**	₹ _____ Hospital Daily cash benefit option: ₹ 200 to ₹ 10,000 per day of hospitalization	NA	Maximum limit on number of days per Policy Year: _____ days (Choose between 30 – 90) Deductible options ☐ 1 day ☐ 2 days Period of hospitalisation as per Benefit Table: ☐ 24 Hours ☐ 48 Hours ☐ 72 Hours
14 b	☐ **Accidental Hospital Daily Cash Benefit Cover**	₹ _____ Accidental Hospital Daily Cash Benefit Options available: ₹ 200 to ₹ 20,000 per day of hospitalization	NA	Maximum limit on number of days per Policy Year: _____ days (Choose between 30 - 90) Deductible options ☐ 1 day ☐ 2 days Period of hospitalisation as per Benefit Table: ☐ 24 Hours ☐ 48 Hours ☐ 72 Hours

14 c	☐ **Worldwide Hospital Daily Cash Benefit Cover**	₹ _____ Worldwide Hospital Daily Cash Benefit Options available: ₹ 200 to ₹ 30,000 per day of hospitalization	NA	Maximum limit on number of days per Policy Year: _____ days (Choose between 30 - 90) Deductible options ☐ 1 day ☐ 2 days Period of hospitalisation as per Benefit Table: ☐ 24 Hours ☐ 48 Hours ☐ 72 Hours
14 d	☐ **Convalescence Benefit Cover**	₹ _____ Sum Insured options available: ₹ 2,000 - ₹ 1 Lac	NA	
14 e	☐ **Companion Benefit Cover**	₹ _____ Sum Insured options available: ₹ 200 to ₹ 10,000 per day of hospitalization	NA	
14 f	☐ **ICU Daily Cash Benefit Cover**	₹ _____ ICU Daily Cash Benefit Options available: ₹ 200 to ₹ 10,000 per day of hospitalization	NA	Maximum limit on number of days per Policy Year: _____ days (Choose between 30 – 90) Deductible options ☐ 1 day ☐ 2 days Period of hospitalisation as per Benefit Table: ☐ 24 Hours ☐ 48 Hours ☐ 72 Hours
14 g	☐ **Chemotherapy and Radiotherapy Benefit**	₹ _____ Sum Insured options available: ₹ 1,000 to ₹ 50,000 per sitting	NA	Maximum limit on number of sittings: _____ From 5 sittings to Unlimited sittings per year
15 a	☐ **Critical Illness Benefit Cover**	₹ _____ Sum insured From ₹ 10,000 to ₹ 1 Crore	NA	NA
15 b	☐ **Critical Illness Indemnity Cover**	₹ _____ Sum insured From ₹ 5,000 to ₹ 1 Crore	NA	NA
15 c	☐ **Expert Opinion On Critical Illness**	NA	NA	Options available: ☐ Domestic Expert Opinion ☐ Worldwide Expert Opinion
15 d	☐ **Loss of Pay Cover**	Sum insured ₹ _____ From ₹ 1,000 to ₹ 1 Lac subject to a maximum of 50 weeks per Policy Year		Any one or combination of the following can be opted under the cover: ☐ Specified Critical Illness ☐ Injury due to an accident leading to Disablement ☐ Any illness where hospitalization is above _____ Days, (Choose between 5 days to 15 days)
16 a	☐ **Accidental Death Benefit Cover**	₹ _____ Sum insured From ₹ 50,000 to ₹ 1 Crore	NA	NA
16 b	☐ **Permanent Total Disablement Benefit Cover**	₹ _____ Sum insured From ₹ 50,000 to ₹ 1 Crore	NA	NA
16 c	☐ **Permanent Partial Disablement Benefit Cover**	₹ _____ Sum insured From ₹ 50,000 to ₹ 1 Crore	NA	NA
17	☐ **Dental Expenses Cover**	₹ _____ Sum Insured options available: From ₹ 1,000 to ₹ 2 Lacs	NA	Any one or combination of the following can be opted under the cover: ☐ Class 1 (Investigative & Preventative Treatment) ☐ Class 2 (Basic Restorative, Periodontal Treatment) ☐ Class 3 (Major Restorative & Orthodontic Treatment) Limit Options available: ☐ Up to the Sum Insured ☐ Up to the Sum Insured with x% co-pay x = _____% (Choose between 10% to 20%)
18	☐ **Vision Expenses Cover**	₹ _____ Sum Insured Options available: From ₹ 1,000 to ₹ 1 Lac	NA	Limit Options available: ☐ Up to the Sum Insured ☐ Up to the Sum Insured with x% co-pay x = _____% (Choose between 10% to 20%)
19	☐ **Refractive Error Correction beyond +/-5 Expenses Cover**		₹ _____ Sub Limit Options available: From ₹ 1,000 to ₹ 1 Lac	

20	☐ **OPD Physiotherapy Charges Cover**	₹ _____ Sum Insured Options available: From ₹ 1,000 to ₹ 50,000	NA	Limit Options available: ☐ Up to the Sum Insured ☐ Up to the Sum Insured with x% co-pay x = _____% (Choose between 10% to 20%)
21	☐ **Routine Immunisations Cover**	NA	₹ _____ Sub-Limit Options available: From ₹ 1,000 to ₹ 25,000	NA
22	☐ **Home Nursing Charges Cover**	NA	₹ _____ Sub Limit Options available: From ₹ 50,000 to ₹ 1 Lac	
23	☐ **Health Check Up Benefit**	NA	NA	Frequency of Health Check-up Options available: ☐ Every year ☐ Every Year after 1st Renewal ☐ Once in 2 Years ☐ Once in 3 Years ☐ Once in 4 Years Dependency on claims to be selected: ☐ Available only subsequent to claim free year ☐ Available irrespective of claim in previous year For a floater policy the cover can be further limited by selecting anyone of options listed below ☐ To Primary Member in Floater policy ☐ To each member
24	☐ **Compassionate Cover for family member in case of Emergency or Accident**	₹ _____ Sum Insured Options available: From ₹ 1,000 to ₹ 1 Lac	NA	NA
25	☐ **Air Ambulance Cover**	NA	₹ _____ Sub Limit Options available: From ₹ 50,000 to ₹ 5 Lacs	NA
26	☐ **Emergency Evacuation Cover**	NA	₹ _____ Sub Limit Options available: From ₹ 50,000 to ₹ 5 Lacs	NA
27	☐ **Medical Equipment Cover**	NA	₹ _____ Sub Limit Options available: From ₹ 5,000 to ₹ 50,000	NA
28	☐ **Bariatric Surgery Cover**	NA	₹ _____ Sub Limit Options available: From ₹ 5,000 to ₹ 5 Lacs	NA
29	☐ **Adventure Sports Cover**	NA	₹ _____ Sub Limit Options available: From ₹ 25,000 to ₹ 1 Crore	
30	☐ **Birth Control Procedure Cover**	NA	₹ _____ Sub Limit Options available: From ₹ 5,000 to ₹ 25,000	NA
31	☐ **Infertility Treatment Cover**	NA	₹ _____ Sub Limit Options available: ₹ 5,000 to ₹ 5 Lacs	Options available: ☐ To be part of maternity Sub Limit ☐ To be in addition to Sub Limit for maternity expenses cover
32	☐ **In-patient hospitalization Cover for Ayush Treatment**	NA	₹ _____ Sub Limit Options available: From ₹ 5,000 to Up to Sum Insured	NA
33	☐ **Enhanced Hospitalization Cover**	Sum insured options available: ☐ x% of the Base Sum Insured x= ____% (Choose between 50% to 300%) Maximum limit of ₹ _____ (Choose any limit up to Sum Insured)		Choose incident to be covered: ☐ Accident ☐ Critical Illness/es (Any one or more Critical Illness/es can be selected from the list of 36 CIs.)
34	☐ **Worldwide Emergency Cover**	NA	Covered up to Base Sum Insured	Choose any one option: ☐ Emergency treatments for all illness including Pre-existing Diseases ☐ Emergency treatments for all illnesses excluding Pre-existing Diseases

35	☐ **Restoration of Sum Insured**	NA	NA	Choose any one of the categories: ☐ Category 1: Upto base SI for unrelated illness ☐ Category 2: Upto base SI for any illness Options available in a Policy Year: ☐ Once ☐ 2 times ☐ 4 times ☐ 9 times ☐ Unlimited times
36	☐ **Cumulative bonus**	NA		Options available: x% of Base Sum Insured per year Maximum up to 100% of the Base Sum Insured x = _____% (x can be any number from 1 to 100) ☐ Non Reducing CB irrespective of claim
37	☐ **Corporate Buffer (At group Level)**	₹ _____ Sum Insured Options available: From ₹ 5,000 to ₹ 10 Crores	NA	The cover can be limited by selecting any one option: ☐ Per person limit ☐ Per policy floater limit (as a % of sum insured per policy year)
38	☐ **Corporate Buffer for Critical Illness only (At group Level)**	₹ _____ Sum Insured Options available: From ₹ 5,000 to ₹ 10 Crores	NA	The cover can be limited by selecting any one option: ☐ Per person limit ☐ Per policy floater limit (as a % of sum insured per policy year)
39	☐ **Healthy Living Reward Program**	NA	NA	*Any one or a combination of following programs can be offered under this program:* ☐ Enrollment into Wellness Program ☐ Health Risk Assessment (HRA) ☐ Targeted Risk Assessment (TRA) ☐ Online Lifestyle Management Program (LMP) ☐ Chronic Condition Management Programs ☐ Participating in ManipalCigna Sponsored Programs and Worksite or Online/Offline Health Initiatives ☐ Health Check Up Healthy Reward Points may be awarded on enrollment in the policy or completing various programs
40	☐ **Condition Management Reward Program**	NA	NA	
41	☐ **Wellness Services Program**	NA	NA	Wellness Services: ☐ Track your Health ☐ Medical Concierge services ☐ Health check up ☐ Medical Practitioner's consultations ☐ Health tips or newsletters ☐ Well-baby Care ☐ Well-Mother Care
42	☐ **Sub-limits Cover**	<< Sub-limits as opted will be displayed >>		

Sr. No.	Waiting Period Clause	Waiting Period	Options
1	☐ **Pre-existing Diseases**	36 Years since date of inception of the cover	_____ Months Choose any number of months from 0 – 36 months
2	☐ **30- day Waiting Period**	30 Days since date of inception of the cover	_____ Days Choose any number of days from 0 – 90 days
3	☐ **Specified disease/procedure Waiting period**	2 Years since date of inception of the cover	_____ Months Choose any number of months from 0 –36 months
4	☐ **Maternity waiting period**	4 Years since date of inception of the cover	_____ Months Choose any number of months from 0 – 48 months
5	☐ **Critical Illness Waiting period**	90 days since date of inception of the cover	_____ Days Choose any number of days from 0 – 90 days
6	☐ **Survival Period for Critical Illness**	30 Days since date of first diagnosis of the covered Critical Illness	_____ Days Choose any number of days from 0 – 30 days

IV. DETAILS OF PREVIOUS INSURER(S) (if renewal)

Are your employees/ members at present insured?	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)
Name of TPA	
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 INSURANCE 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 (INR): _____ Payment Option (pl. tick (√)): ☐ Cheque ☐ DD ☐ Fund Transfer

Amount In words: _____

Payment Frequency : ☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Single ☐ Annually

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

Instrument no.: _____ Instrument Date: _____ Instrument Amount: _____

Bank Name: _____

Name of 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 authorised 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 anytime 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: _____

Signature of Proposer: _____

Place: _____

In my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised 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),

VIII. ADVISOR/ INTERMEDIARY DECLARATION :

information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein that 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 further confirm that I have explained the product features, terms and conditions to the prospect and the product opted is suitable to the needs of the customer.
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:_____

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 or renew 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 prospectuses or tables of the insurers.
2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Insurance is a subject matter of solicitation

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.

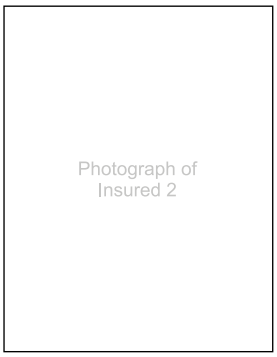
Instructions:

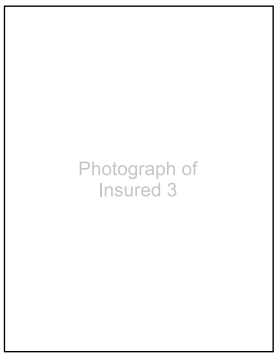
- Ÿ It is important for these electronic payment systems that the Policy Holder's name in the Policy must exactly match with the name in the Bank Account records/details given above.
- Ÿ In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required.
- Ÿ 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.
- Ÿ Cancelled cheque should be attached along with the NEFT format.
- Ÿ 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.
- Ÿ NEFT Form needs to be complete in all respect.

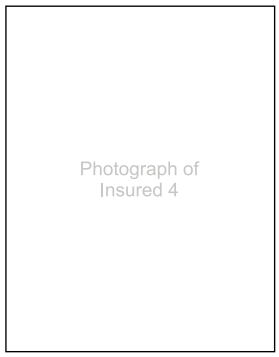
Date: D D M M Y Y Y Y

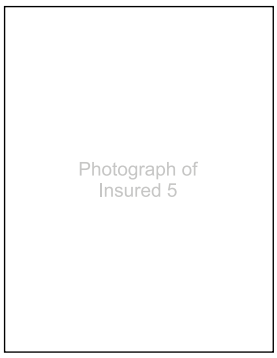
Signature of Proposer/Authorized Representative*:_____
(A policyholder or prospect, who is a person with disability, may duly authorize a representative to give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)

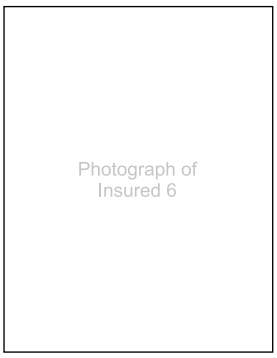
Annexure - A
KYC of Beneficial owners

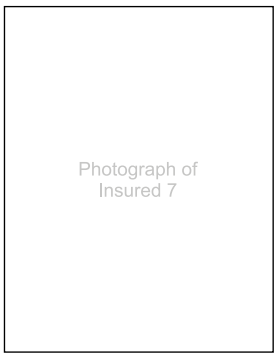


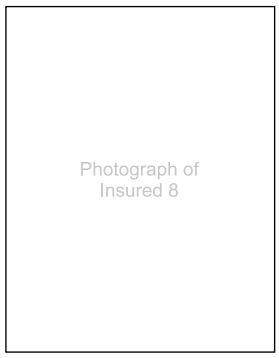












Title* : Mr. ☐ Mrs. ☐ Ms. ☐ Gender*: Male ☐ Female ☐ Others ☐ Tick if Employer

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

Beneficial Owner Name*: F I R S T* M I D D L E L A S T*
(as in bank account)

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

Present Address* :
(As per the KYC proof submitted)
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 : Document Expiry date: D D M M Y Y Y Y
(Please mention only last four digits of your Aadhaar or VID)

CKYC number : EIA number:

PEP or relative of PEP :