Proposal Form No.: ______

ManipalCigna Health Insurance Company Limited
(Formerly known as CignaTTK Health Insurance Company Limited)
Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (E), Mumbai - 400063. IRDAI Registration No. 151.
Call (Toll Free): 1800-102-4462 **Visit:** www.manipalcigna.com
E-mail: customercare@manipalcigna.com **CIN No.**: U66000MH2012PLC227948

ManipalCigna Health Insurance

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

FOR OFFICE USE ONLY

Branch Name: | Branch Code:

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

Business Type: Urban /Social / Rural

Ops Tags: Employee DMS Code: ManipalCigna Employee DMS Code | Partner Vertical Name: Partner Business Vertical Code | Partner Branch ID: Partner Branch Code

Sub Intermediary Name: <<For POSP>> | Sub Intermediary PAN: <<For POSP>> | Other Details: <<For POSP>>

Ref. A
Ref. B
Ref. C

MANIPALCIGNA PROHEALTH INSURANCE
PROPOSAL FORM

1 Please fill the form in BLOCK LETTERS.
2 All details marked with* are mandatory.
3 The Proposer must authenticate the cancellations/alterations in this form.

For Staff Rebate# please provide: Name of the organization: ______

Name of the Employee: ______ Employee ID: ______

#(Applicable only if Proposer or any Insured person under the policy is employee of: ManipalCigna, Promoter group of ManipalCigna)

The issuance of this form by ManipalCigna Health Insurance Company Limited (the Company) does not amount to acceptance of proposal. The actual liability of the Company does not commence until this proposal has been accepted by the Company and premium realized.

I. PROPOSER DETAILS*:

Title* : Mr. ☐ Mrs. ☐ Ms. ☐
Gender* : Male ☐ Female ☐ Others ☐
Tick if Employer is the Payor: ☐
Date of Birth* : D D M M Y Y Y Y
Marital Status* : Married ☐ Single ☐ Others ☐

Name*(as in bank account): FIRST NAME* | MIDDLE NAME | SURNAME*

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

Correspondence Address*:
If same as above, please tick here ☐
Landmark:
City* : Town (District):
State*: Pin Code*:
Gram Panchayat:

Email Address* : Address 1 Address 2

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

ManipalCigna ProHealth Insurance Proposal Form | UIN: MCIHLIP25024V082425 | URN: 2024/PHLT/V8.01 | October 2024

Would you like to subscribe to important alert on Whatsapp? Yes ☐ No ☐

Policyholders have the option to access their Policy documents through DigiLocker with no additional charges.

To learn more about DigiLocker, please visit https://www.manipalcigna.com/video/

Would you prefer to receive all policy document digitally (via email/soft copy)?

☐ Yes (I would like to receive policy document digitally). ☐ No (I prefer to receive policy document in hard copy).

Occupation* : Government Service ☐ Private Service ☐ Self Employed ☐ Others ☐ ________

Annual Income* : Up to ₹50,000 ☐ ₹5 to ₹10 Lacs ☐ ₹15 to ₹20 Lacs ☐

₹50,000 to ₹5 Lacs ☐ ₹10 to ₹15 Lacs ☐ Above ₹20 Lacs ☐

Educational Qualification* : Less than class X ☐ Class X ☐ Class XII ☐ Graduate ☐ Post Graduate ☐ Professional Degree ☐

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

Residential status* : ☐ Indian ☐ NRI If NRI, Please mention country ________ ☐ Others (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):

CKYC number : EIA number:

PEP or relative of PEP:

Family Physician Details:

Name : FIRST NAME MIDDLE NAME SURNAME

Contact number : Email id:

Address :

Do you wish to assign a Caregiver for your Policy/ies: Yes ☐ No ☐ If Yes, please provide:

Name* : FIRST NAME* MIDDLE NAME SURNAME*

Mobile number* : Relationship with Proposer:

Age (in Years) : Email id:

Caregiver can be a close family member who would take care of the Insured Person in any kind of health care event, whether emergency or planned. The Caregiver might not be the SOS contact.

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

II. NOMINEE DETAILS*:

Is the Nominee same as Caregiver (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	Correspondence 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# Mobile No. E-mail ID Relationship with Nominee			

As per recent regulatory mandate, nomination details are mandatory to be provided by the customers. Please provide your nominee details urgently by emailing us at customercare@manipalcigna.com; contacting us on 1800-102-4462, or visit our nearest branch.

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.

#A Minor should not be declared as Appointee.

III. POLICY/PLAN DETAILS*:

Tenure*: 1 Year ☐ 2 Years ☐ 3 Years ☐

Proposed Policy Period: From D D M M Y Y Y Y at __ : __ **Hrs**

(Must be on or later than instrument date/ premium payment date)

IV. INSURED DETAILS*: (Deductible and Sum Insured only for individual cover)

Sr No.	Name (First*,Middle, Last*)	Gender* (M/F/O)	DOB*	Relationship with Proposer*	ABHA No.^^^	Height* (Cms)	Weight* (Kgs)	Occupation/ Industry Type/ Nature of Job*	City*	Deductible	Sum Insured* (only for individual cover)	HMB (Only for ProHealth Accumulate)	Insured Address If Different From Proposer	If PEP/ Relatives of PEP^ (Y / N)	C-KYC number
1															
2															
3															
4															
5															
6															
7															
8															

^Politically exposed person
If PEP details are not provided, we will consider the same as “No”.
^^^Please provide ABHA number (Ayushman Bharat Health Account number) for all the proposed Insured Persons. In case the ABHA number is not available for any Insured Person, you may request to create an ABHA number by visiting the web link: https://healthid.ndhm.gov.in/register

Note:
· ManipalCigna Critical Illness Add On Cover: Minimum age at entry under this policy is 18 years and maximum age at entry is 65 years.

All insured Indian national and Indian residents? Yes ☐ No ☐ If No, Please mention country ____________________

Plan Type* : Individual ☐ Floater ☐ | **Portability:** Yes ☐ No ☐ (If yes portability form to be completed and attached) | **Migration:** Yes ☐ No ☐ (If yes migration form to be completed and attached)

	Protect Plan	Plus Plan	Preferred Plan	Premier Plan	Accumulate Plan
Sum Insured	☐ ₹2.5 Lacs ☐ ₹7.5 Lacs ☐ ₹25 Lacs ☐ ₹3.5 Lacs ☐ ₹10 Lacs ☐ ₹30 Lacs ☐ ₹4.5 Lacs ☐ ₹15 Lacs ☐ ₹50 Lacs ☐ ₹5.5 Lacs ☐ ₹20 Lacs	☐ ₹4.5 Lacs ☐ ₹20 Lacs ☐ ₹5.5 Lacs ☐ ₹25 Lacs ☐ ₹7.5 Lacs ☐ ₹30 Lacs ☐ ₹10 Lacs ☐ ₹50 Lacs ☐ ₹15 Lacs	☐ ₹15 Lacs ☐ ₹30 Lacs ☐ ₹50 Lacs	☐ ₹100 Lacs	☐ ₹5.5 Lacs ☐ ₹20 Lacs ☐ ₹7.5 Lacs ☐ ₹25 Lacs ☐ ₹10 Lacs ☐ ₹30 Lacs ☐ ₹15 Lacs ☐ ₹50 Lacs
Optional Deductible	☐ ₹1 Lac ☐ ₹4 Lacs ☐ ₹10 Lacs ☐ ₹2 Lacs ☐ ₹5 Lacs ☐ ₹3 Lacs ☐ ₹7.5 Lacs	☐ ₹1 Lac ☐ ₹5 Lacs ☐ ₹2 Lacs ☐ ₹7.5 Lacs ☐ ₹3 Lacs ☐ ₹10 Lacs ☐ ₹4 Lacs	Not Available	Not Available	☐ ₹50,000 ☐ ₹4 Lacs ☐ ₹1 Lac ☐ ₹5 Lacs ☐ ₹2 Lacs ☐ ₹7.5 Lacs ☐ ₹3 Lacs ☐ ₹10 Lacs
HMB	₹500	₹2000	₹15000	₹15000	**HMB Option** ☐ ₹5000 ☐ ₹15000 ☐ ₹10000 ☐ ₹20000

Applicable Discounts:
a. **Family Discount** of 25% for Protect and Plus Plans covering 2 and more family members under the same policy under the individual policy option.
b. **Long Term policy discount** of 7.5% for selecting a 2 year policy and 10% for selecting a 3 year policy. The discount is available only with 'Single' premium payment mode.
c. ☐ **Worksite Discount** Worksite Code: ________ Employee id: ________

Premium payment mode: ☐ Monthly^ ☐ Quarterly ☐ Half yearly ☐ Yearly ☐ Single
^2 months premium to be paid in advance and instalment/renewal premium payment through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card).

Optional Covers: (Deductible and Voluntary Co-pay cannot be opted under the same plan)
☐ Reduction in Maternity Waiting Period (Maternity waiting period reduced from 48 months to 24 months. Available with ProHealth Plus, Preferred, Premier plan only))
☐ Voluntary Co-pay (please specify) ☐ 10% ☐ 20%
A discount of 7.5% for opting 10% Co-pay and a discount of 15% for opting a 20% Co-pay on the Policy in case of Protect and Plus Plan. A discount of 5% for opting 10% Co-pay and 10% for opting 20% Co-pay on the Policy in case of Accumulate Plan.
☐ Waiver of Mandatory Co-pay
☐ Cumulative Bonus Booster
☐ Hospital Daily Cash Benefit

☐ **ManipalCigna Critical Illness Add On Cover [UIN: MCIHLIP21128V022021]**

☐ **ManipalCigna Health 360 [UIN: MCIHLIA23023V012223]**

☐ ManipalCigna Health 360 - Shield	☐ ManipalCigna Health 360 - Advance	☐ ManipalCigna Health 360 - OPD (Opt any one of the Packages below and Sum Insured)		
Non-Medical Items	Restoration of Sum Insured	☐ Package 1	☐ Package 2	☐ Package 3
Durable Medical Equipment	Room Accommodation Upgrade	☐ ₹5,000	☐ ₹10,000	☐ ₹20,000
	Air Ambulance	☐ ₹10,000	☐ ₹15,000	☐ ₹25,000
		☐ ₹15,000	☐ ₹20,000	☐ ₹30,000
		☐ ₹20,000	☐ ₹25,000	☐ ₹40,000
			☐ ₹30,000	☐ ₹50,000
			☐ ₹40,000	☐ ₹60,000
			☐ ₹50,000	☐ ₹70,000
			☐ ₹60,000	☐ ₹80,000
			☐ ₹70,000	☐ ₹90,000
			☐ ₹80,000	☐ ₹100,000
			☐ ₹90,000	
			☐ ₹100,000	

Zone of Cover: (Please tick against your Zone): ☐ Zone I ☐ Zone II ☐ Zone III

Zone I: Mumbai, Thane & Navi Mumbai, Gujarat and Delhi & NCR
Zone II: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Kolkata, Pune
Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

a) Persons paying Zone I premium can avail treatment all over India without any Co-pay.
b) Persons paying Zone II premium
   i) Can avail treatment in Zone II and Zone III without any Co-pay.
   ii) Availing treatment in Zone I will have to bear 10% of each and every claim.
c) Person paying Zone III premium
   i) Can avail treatment in Zone III, without any Co-pay.
   ii) Availing treatment in Zone II will have to bear 10% of each and every claim.
   iii) Availing treatment in Zone I will have to bear 20% of each and every claim.

Your default zone is based on the city mentioned in your correspondence address.

Note: Please note that your Policy period will start from premium received date at our branch office in case of cash payments or/ as per instrument date when paying through Cheque/ demand draft/ pay order. In case of credit card/ debit card transactions, Policy period will start from date of debit of requisite premium from the Proposer's card/ bank account.

ManipalCigna Prime Plus [UIN: MCIHLIA25005V012425]

(Below riders are available only with ManipalCigna ProHealth Insurance - Protect and Plus plans)

☐ Room Rent Modification (Twin Sharing AC room)

☐ Supreme Bonus (Applicable with Sum Insured Rs. 5 Lacs and above up to Rs. 50 Lacs) (Can be opted only when Cumulative Bonus Booster optional cover is not opted)

☐ Deductible

☐ Rs. 10000 ☐ Rs. 25000

V. MEDICAL AND LIFESTYLE INFORMATION*:

	Medical questions	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q1	Has any of the applicant ever been diagnosed with or suspected to have <<Cancer or Rheumatoid Arthritis or Ulcerative Colitis or Crohn's disease or Chronic Liver Disease, Hepatitis B, Cirrhosis or Chronic Kidney Disease or Kidney failure or Epilepsy or Fits or Stroke or Paralysis or Parkinsonism or Alzheimer's or Multiple sclerosis or Brain Tumor or Cerebral Palsy or Heart Failure or Heart Attack or Angina or Coronary Artery Disease or Ischemic Heart Disease or Chronic Bronchitis or Intestitial Lung Diseases or Pneumoconiosis or Emphysema.>> (If Yes, tick against the disease)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
i	Cancer	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
ii	Rheumatoid Arthritis / Ulcerative Colitis / Crohn's disease	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
iii	Chronic Liver Disease, Hepatitis B, Cirrhosis	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
iv	Chronic Kidney Disease / Kidney failure	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
v	Diseases of the Brain - Epilepsy/Fits/Stroke/Paralysis/Parkinsonism /Alzheimer's/Multiple sclerosis/Brain Tumor/ Cerebral Palsy	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
vi	Diseases of Heart - Heart Failure/Heart Attack/Angina/Coronary Artery Disease/Ischemic Heart Disease	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
vii	Chronic diseases of the Lungs - Chronic Bronchitis/ Intestitial Lung Diseases/ Pneumoconiosis/ Emphysema	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Q2	Has any member ever suffered or currently suffering from or under treatment (operated, hospitalised, investigated) or been under medication for more than a week for any medical condition.	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
i	**Diabetes Mellitus**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	How does the applicant manage his/her diabetes / pre-diabetes?								
a	Insulin	☐	☐	☐	☐	☐	☐	☐	☐
b	Oral diabetic medication	☐	☐	☐	☐	☐	☐	☐	☐
c	No medicine	☐	☐	☐	☐	☐	☐	☐	☐
d	Any other treatment	☐	☐	☐	☐	☐	☐	☐	☐
2	How many medicines does the applicant take to manage his/her diabetes / pre-diabetes?								
a	No medicine	☐	☐	☐	☐	☐	☐	☐	☐
b	One medicine	☐	☐	☐	☐	☐	☐	☐	☐
c	Two medicines	☐	☐	☐	☐	☐	☐	☐	☐
d	Three or more medicines	☐	☐	☐	☐	☐	☐	☐	☐
3	When was the applicant first diagnosed with diabetes / pre-diabetes?								
a	1 - 5 years	☐	☐	☐	☐	☐	☐	☐	☐
b	5 - 10 Years	☐	☐	☐	☐	☐	☐	☐	☐
c	10 - 15 years	☐	☐	☐	☐	☐	☐	☐	☐
d	More than 15 Years	☐	☐	☐	☐	☐	☐	☐	☐
ii	**Hypertension**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	How does the applicant manage his/her Hypertension / High Blood Pressure?								
a	No medicine	☐	☐	☐	☐	☐	☐	☐	☐
b	One medicine	☐	☐	☐	☐	☐	☐	☐	☐
c	Two medicines	☐	☐	☐	☐	☐	☐	☐	☐
d	Three or more medicines	☐	☐	☐	☐	☐	☐	☐	☐
2	When was the applicant first diagnosed with Hypertension / High Blood Pressure?								
a	1 - 5 years	☐	☐	☐	☐	☐	☐	☐	☐
b	5 - 10 Years	☐	☐	☐	☐	☐	☐	☐	☐
c	10 - 15 years	☐	☐	☐	☐	☐	☐	☐	☐
d	More than 15 Years	☐	☐	☐	☐	☐	☐	☐	☐
iii	**High Cholesterol**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
1	Is any of the applicant under medication for high cholesterol / high triglycerides								

a	Yes								
b	No								
iv	**Thyroid disorders**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Which thyroid disorder is the applicant suffering from?								
a	Goitre								
b	Hyperthyroidism (high thyroid activity)								
c	Hypothyroidism (low thyroid activity)								
d	Other thyroid disorders								
e	Thyroid Nodule								
f	Thyroditis								
g	Any other								
v	**Heart and Lung disorders**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Asthma								
2	Tuberculosis								
3	Upper Respiratory Tract Infection								
4	Lower Respiratory Tract Infection								
5	Varicose veins								
6	DVT (Deep vein thrombosis)								
7	Syncope								
8	Hypotension (Low Blood Pressure)								
9	Varicocele								
10	Lung Abscess								
11	Allergic Bronchitis								
12	Any other heart and lung condition								
vi	**Digestive system disorders (Stomach and related organs)**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Peptic ulcer (Ulcer in stomach or duodenum)								
2	Appendicitis								
3	Cholecystitis/Cholelithiasis (Gall Bladder stones)								
4	Hemorrhoids(Piles)								
5	Anal Fissure								
6	Anal Fistula								
7	Pancreatitis								
8	Umbilical Hernia (Hernia at navel)								
9	Inguinal Hernia (Hernia in groin)								
10	Irritable bowel syndrome								
11	Fatty liver								
12	Any other								
vii	**Brain, nerve and Psychiatric (Mental) disorders**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Recurring or severe headaches / Migraine								
2	Febrile Convulsions								
3	Vertigo (Recurrent dizziness)								
4	Encephalitis								
5	Mental Retardation								
6	Anxiety								
7	Depression								
8	Psychosis								
9	Any other psychological disorders								
10	Dementia (Memory loss)								
11	Attention deficit Disorder								
12	Any other								
viii	**Other Endocrine (Hormonal) disorders**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Parathyroid gland disorders								
2	Adrenal Disorder								
3	Pituitary Disorders								
ix	**Bone, joints and muscle disorders**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

1	Gout / Hyperuricemia (high uric acid in blood)								
2	Osteoarthiritis								
3	Shoulder Dislocation								
4	Spondylitis / Spondylosis								
5	Osteoporosis								
6	Prolapse of Inter-vertebral disc (disc prolapse)								
7	Total Knee Replacement								
8	Total Hip Replacement								
9	Any other								
x	**Ear, nose, eye and throat disorders**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Otitis-media (middle ear infection)								
2	Hearing loss								
3	Nasal Polyp								
4	Sinusitis								
5	Deviated Nasal Septum								
6	Tonsillitis								
7	Pharyngitis (throat infection)								
8	Cataract								
9	Glaucoma								
10	Vocal Cord Nodule								
11	Any other								
xi	**Genito-urinary and Gynaecological disorders**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Kidney / bladder stones								
2	Recurrent Urinary tract infection								
3	Stricture Urethra								
4	Cytitis/ Infection of urinary bladder								
5	Urinary incontinence								
6	Benign Hypertrophy of Prostate								
7	Hydrocele								
8	Torsion of testes								
9	Phimosis								
10	Breast lump / Cyst / abscess								
11	Ovarian cyst								
12	Endometriosis								
13	Fibroid Uterus								
14	Menstrual disorder / irregular or excessive bleeding								
15	Bartholin's abscess / cyst								
16	Vaginal prolapse								
17	Cervical polyp								
18	Any other								
xii	**Blood and related disorders**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Anaemia								
2	Thalassaemia								
3	Sexually transmitted diseases								
4	HIV / AIDS (Acquired Immuno-deficiency syndrome)								
xiii	**Skin disorders**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Psoriasis								
2	Eczema								
3	Dermatitis								
4	Urticaria								
5	Vitiligo								
6	Cyst/ lump/ growth / polyp / tumour								
7	Any other								
xiv	**Any other condition / illness / disorder / surgery**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

Q3	Has any of the applicants recommended to undergo or has undergone any pathologic or radiologic tests for any illness other than the ones listed above and routine or annual health check-up?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Q4	Is any applicant currently not in good health and undergoing any Investigation or treatment or medication for any illness or medical condition (Physical/ Mental/ Sleep disorders)?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Habits and Lifestyle questions		**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**	**Insured 7**	**Insured 8**
Q5	Does any of the insured/s chew tobacco/ smoke/ consume alcohol? Please tick the relevant box(es) below	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
A	**Smoke**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	Since how long does the applicant smoke								
a	<=20 years								
b	>20 years								
B	**Tobacco**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	How many Pan masala/gutka packets does the applicant has in a day								
a	1-3 packets/day								
b	4-6 packets/day								
c	>6 packets/day								
C	**Alcohol**	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
1	How frequently does the applicant consume alcohol								
a	1-3 days/ week								
b	3-6 days / week								
c	Daily								
For Lifestyle Protection – Critical Illness Add On Cover		**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**	**Insured 7**	**Insured 8**
Q6	Have any first degree relatives (i.e. parents, brothers, sisters or children) of any of the applicants (who are not themselves applicants for this insurance policy) had cancer, motor neuron disease or any other hereditary disorders	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

VI. ADDITIONAL MEDICAL INFORMATION:

If answers to Q2 and Q5 are “Yes”, please provide further details below. Please attach extra sheets if required.

Sr.No.	Additional Medical Information	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
a.	Exact Diagnosis								
b.	Year of diagnosis								
c.	Treatment taken: Surgical/ Medical / No treatment / Defaulter (left treatment on own)								
d.	Current status - Cured/ On treatment / Pending surgery or treatment								
e.	Complications/ Recurrences - Yes/No								
f.	Last consultation date - "Month/Year" to be provided								
g.	Histopathology Examination Report (only for surgical) - No abnormality, Malignancy/ borderline malignancy/ Tuberculosis								

VII. PREVIOUS INSURANCE DETAILS:

Please fill the following details with respect to health insurance policies(s) currently or held with the Company or any other insurance company (Individual or Group)?

Insured	Policy No.	Type of Policy e.g. Mediclaim, PA, CI, Hospital Cash	Insurer Name	From Date	To Date	Sum Insured	Claim Details			Cumulative Bonus Earned		Has any proposal for life, health, hospital daily cash or critical illness insurance on the life of the applicant ever been declined, postponed, loaded or been made subject to any special conditions such as exclusions by any insurance company?
							Claim Number	Claimed Amount	Ailment	%	Amount	
Insured 1												☐ YES ☐ NO
Insured 2												☐ YES ☐ NO
Insured 3												☐ YES ☐ NO
Insured 4												☐ YES ☐ NO
Insured 5												☐ YES ☐ NO
Insured 6												☐ YES ☐ NO
Insured 7												☐ YES ☐ NO
Insured 8												☐ YES ☐ NO

Signature of Proposer *:________________________________

(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)

VIII. Current Insurance Details

In the unfortunate event of claim, the below information will facilitate Us, in case you have chosen Us as a Primary insurer to coordinate with other insurers to ensure the hassle free settlement of your claim as per the applicable policy terms and conditions.

Please fill the following details with respect to health indemnity insurance policies(s) currently with any other insurance company?

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							

For active policies, please attach policy copies.
Insured wise information required with all the above information in Current Insurance Details.

IX. PAYMENT DETAILS*:

Premium Paid by : <First> <Middle> <Last>______ Relationship to Proposer : ______________

Premium Amount : ________________________ in Words ________________________

Signature : ________________________

Payment Option: Cheque ☐ Demand Draft ☐ Pay Order ☐ Credit Card ☐ Debit Card ☐ Cash ☐

For Cheque / DD / Credit Card/ Debit Card/ PO/ Others (Please specify)___________(Payable in favour of "ManipalCigna Health Insurance Company Limited" – Proposal form No.__________________)

Instrument / Transaction Number : ________________________ Instrument/Transaction Date: D D M M Y Y Y Y

Instrument /Transaction Amount : ________________________

Bank Name : ____

Payment to be collected only from Proposers Card/Bank Account

X. 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:

- 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 *:____________________

(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)

XI. 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 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, including seeking and/or sharing of my medical data through ABHA.

☐ I hereby consent to and authorize ManipalCigna Health Insurance Company Limited (“Company”) and its representatives to collect, use, share and disclose information provided by me, as per the privacy policy of the Company. Company or its representatives are also hereby authorised to contact me (including overriding my registry on NCPR/NDNC and/or under any extant TRAI regulations) and / or notify about the services being rendered by the Company.

Further, I hereby provide my consent and authorize Company and its representatives to collect the premium upfront at proposal stage. I hereby further declare that I am also aware of the recent regulatory changes (details available at https://irdai.gov.in/web/guest/document-detail?documentId=5625747), wherein Insurer has been asked to collect premium after acceptance of proposal, however it would be difficult for me to subsequently submit premium at later stage to the insurer and hence I hereby request and authorize Insurer to accept my premium along with this proposal to avoid any inconvenience to me, at my sole cost and consequences.

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 *:____________________

(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)

XII. VERNACULAR DECLARATION:

I hereby declare that, I have fully explained the contents of the proposal form and terms and conditions of the Policy to the Proposer in the language understood to him/her and that the Proposer has affixed the thumb impression above after fully understanding the contents thereof.

Date: D D M M Y Y Y Y **Place:** ____________________

Signature of Proposer *:____________________

(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)

XIII. ADVISOR / INTERMEDIARY DECLARATION*:

I,________________(Full Name) 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), 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: D D M M Y Y Y Y **Place:** ____________________ **Signature of Agent:**

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 the 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 published prospectuses or tables of the insurer.
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.

✂

ACKNOWLEDGEMENT: (Tear Off)

Received from Ms / Mrs / Mr

a sum of ₹ __________ through Cash/Cheque/DD/Credit Card/Debit Card No. ____________________ against your proposal for __________ Policy.

Signature of ManipalCigna official / Intermediary: Date:

ManipalCigna official / Intermediary Name:

Time: Place:

Note: Neither the submission of a completed proposal for insurance or any payment for any Policy sought oblige the Company to agree to issue a Policy, which decision is and always shall be in the Company's sole and absolute discretion.

If ManipalCigna Health Insurance Company Limited accepts a proposal for insurance, it shall be subject to the board approved underwriting policy of the Company and the Policy terms and conditions of this product and the Company shall have no liability to make any payment if premium is not received by ManipalCigna Health Insurance Company Limited in full and in time, or is not realised.

Should you choose to pay premium by Cash, you are advised to do so only at the nearest ManipalCigna branch or its authorised collection points. Handing over cash to any Advisor/ Employee is solely at your own risk and the Company shall in no way be held responsible for any loss in this regard.

Insurance is a subject matter of solicitation.

ManipalCigna ProHealth Insurance Proposal Form | UIN: MCIHLIP25024V082425 | URN: 2024/PHLT/V8.01 | October 2024