

Proposal Form No.:

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

**MANIPALCIGNA PROHEALTH PRIME
PROPOSAL FORM**

Ref. C

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. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>	Gender*	: Male <input type="checkbox"/> Female <input type="checkbox"/> Others <input type="checkbox"/>	Tick if Employer is the Payor: <input type="checkbox"/>
Date of Birth*	: DD MM YYYY	Marital Status*	: Married <input type="checkbox"/> Single <input type="checkbox"/> Others <input type="checkbox"/>	
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 <input type="checkbox"/>	Landmark: City*: Town (District): State*: Pin Code*: Gram Panchayat:			
Email Address*	: Address 1	Address 2		
Telephone Number(s)	: Mobile*: Office(Optional):	Residence (Optional):		

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 ☐ 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 ☐

Aadhaar number^^/ (VID number):

CKYC number : EIA number:

PEP or relative of PEP:

Family Physician Details:

Name : F I R S T N A M E M I D D L E N A M E S U R N A M E

Contact number : Email id:

Address :

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

Name* : F I R S T N A M E * M I D D L E N A M E S U R N A M E *

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

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 <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/>	Proposed Policy Period: From <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> at <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hrs (Must be on or later than instrument date/ premium payment date)
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INSURED DETAILS*: (Sum Insured and deductible only for individual cover)

Particulars	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5
Name (First*, Middle, Last*)					
Gender*					
DOB*					
Relationship with Proposer*					
ABHA Number^^^					
Height* (Cms)					
Weight* (Kgs)					
Gainful Annual Income* (In Case Personal Accident Optional Cover is opted)					
Occupation/ Industry Type/ Nature of Job*					
City*					
Deductible					
Outpatient Expenses* (For Advantage Plan)					
Sum Insured* (only for individual cover)					
Insured address if different from Proposer (Address, Gram Panchayat, City, Town (District), State/Pin Code)					
If PEP/ Relatives of PEP^ (Yes/ No)					
C-KYC number					

^ 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>.

*Are all insured Indian National and Indian Residents? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Please mention country _____			
Plan Type*: Individual <input type="checkbox"/> Floater <input type="checkbox"/> <small>(Active Plan is available only on Individual/Multi-individual basis)</small>		Portability: Yes <input type="checkbox"/> No <input type="checkbox"/> <small>(If yes portability form to be completed and attached)</small>	Migration: Yes <input type="checkbox"/> No <input type="checkbox"/> <small>(If yes migration form to be completed and attached)</small>
	Protect	Advantage	Active
Sum Insured	<input type="checkbox"/> ₹3 Lacs <input type="checkbox"/> ₹4 Lacs <input type="checkbox"/> ₹5 Lacs	<input type="checkbox"/> ₹5 Lacs <input type="checkbox"/> ₹7.5 Lacs <input type="checkbox"/> ₹10 Lacs	<input type="checkbox"/> ₹3 Lacs <input type="checkbox"/> ₹5 Lacs
	<input type="checkbox"/> ₹7.5 Lacs <input type="checkbox"/> ₹10 Lacs <input type="checkbox"/> ₹12.5 Lacs	<input type="checkbox"/> ₹12.5 Lacs <input type="checkbox"/> ₹15 Lacs <input type="checkbox"/> ₹20 Lacs	<input type="checkbox"/> ₹7.5 Lacs <input type="checkbox"/> ₹10 Lacs
	<input type="checkbox"/> ₹15 Lacs <input type="checkbox"/> ₹20 Lacs <input type="checkbox"/> ₹25 Lacs	<input type="checkbox"/> ₹25 ₹Lacs <input type="checkbox"/> ₹30 Lacs <input type="checkbox"/> ₹40 Lacs	<input type="checkbox"/> ₹12.5 Lacs <input type="checkbox"/> ₹15 Lacs
	<input type="checkbox"/> ₹30 Lacs <input type="checkbox"/> ₹40 Lacs <input type="checkbox"/> ₹50 Lacs	<input type="checkbox"/> ₹50 Lacs <input type="checkbox"/> ₹100 Lacs	
	<input type="checkbox"/> ₹100 Lacs		
Optional Deductible <small>(Not available on opting Assure optional package under Protect Plan)</small>	<input type="checkbox"/> ₹10000 <input type="checkbox"/> ₹25000	Not Available	Not Available
Outpatient Expenses (OPD)	Not Available	<input type="checkbox"/> ₹20,000 <input type="checkbox"/> ₹30,000 <input type="checkbox"/> ₹50,000	Not Available
Applicable Discount for Protect and Advantage Plan:			
a. Long term discount: (Applicable only with Single premium payment mode) i. For Policy Period of 2 years - 7.5% on the total applicable premium ii. For Policy Period of 3 years - 10% on the total applicable premium			
b. Employee discount: 10% discount on the premium			
c. <input type="checkbox"/> Worksite Marketing discount (Only at inception - One time) - 10% discount on the premium Tick <input checked="" type="checkbox"/> if applicable Worksite Code: <input type="text"/> Employee id: <input type="text"/>			
d. Family discount: (Applicable only with cover on individual basis) 20% discount on the premium is applicable for covering 2 or more members under the same individual Policy.			
e. Standing Instruction discount: 3% discount on the renewal premium, if the renewal premium is received through standing instruction			
f. ManipalCigna Existing Customer discount (Only at inception - One time): 5% discount will be applicable to the existing customers of ManipalCigna Health Insurance under Group / Retail Policy (excluding Portability and Migration Policies). Please fill the below details: ManipalCigna Group/Retail Policy No: _____ Certificate No(in case of Group Cover): _____ Employee ID: (In case of Employer Employee Cover): _____ Name of the Organization where Employee works: _____			
g. No Claim Discount - 1% no claim discount at renewal, in case insured does not made any claim in expiring policy tenure.			
Maximum discount in any Policy Year cannot exceed 40%.			

Applicable Discount for Active Plan:

a. Long term discount: (Applicable only with Single premium payment mode)

i. For Policy Period of 2 years - 7.5% on the total applicable premium

ii. For Policy Period of 3 years - 10% on the total applicable premium

b. Worksite Marketing discount (Only at inception - One time) - 10% discount on the premium

Tick ☒ if applicable

Worksite Code: Employee id:

c. Standing Instruction discount: 3% discount on the renewal premium, if the renewal premium is received through standing instruction.

d. No Claim Discount - 1% no claim discount at renewal, in case insured does not made any claim in expiring policy tenure.

Premium payment mode: Monthly^ ☐ Quarterly ☐ Half yearly ☐ Single ☐
*3 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 Packages

☐ Enhance Plus (applicable for Protect Plan)

OR

☐ Assure (applicable for SI ₹ 3 Lacs, ₹ 4 Lacs and ₹ 5 Lacs under Protect Plan)

OR

☐ Enhance (applicable for Advantage Plan)

OR

☐ Freedom (applicable for Protect and Advantage Plans)

Optional Covers

Protect	Advantage	Active
<div><input type="checkbox"/> Non-Medical Items</div> <div><input type="checkbox"/> Personal Accident Cover</div> <div><input type="checkbox"/> Cumulative Bonus Booster (applicable for SI ₹ 5 Lacs and above)</div> <div><input type="checkbox"/> Infertility Cover (Available only on opting optional packages Enhance Plus under Protect Plan or Enhance under Advantage Plan applicable for SI>= ₹ 7.5 Lacs) (The cover shall cease upon the eligible Insured Person attaining 60 years of age)</div>		<div><input type="checkbox"/> Non-Medical Items Cover</div> <div><input type="checkbox"/> Worldwide Accidental Emergency Hospitalization</div> <div><input type="checkbox"/> Waiver of Mandatory Co-payment</div> <div><input type="checkbox"/> Health Check Up (applicable for Adult only) as against the Condition Management Program</div> <div><input type="checkbox"/> Waiver of Disease Specific Sublimit</div>
<div><input type="checkbox"/> ManipalCigna Critical Illness Add On Cover [UIN: MCIHLIP21128V022021] 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.</div>		Not Available
<div><input type="checkbox"/> ManipalCigna Prime Plus [UIN: MCIHLIA25005V012425]</div>		<div><input type="checkbox"/> ManipalCigna Prime Plus [UIN: MCIHLIA25005V012425]</div>

<div><input type="checkbox"/> Room Rent Modification<div><input type="checkbox"/> Any room; ICU Up to Sum Insured</div><div><input type="checkbox"/> Twin Sharing AC room; ICU Up to Sum Insured</div></div>		<div><input type="checkbox"/> Room Rent Modification (Applicable with Sum Insured 5 Lacs and above)<div><input type="checkbox"/> Any room; ICU Up to Sum Insured</div><div><input type="checkbox"/> Twin Sharing AC room; ICU Up to Sum Insured</div></div>
<div><input type="checkbox"/> Surplus Benefit (Applicable with Sum Insured ₹ 5 Lacs and above)</div>		Not Available
<div><input type="checkbox"/> Supreme Bonus (Applicable with Sum Insured ₹ 5 Lacs maximum Up to ₹ 50 Lacs) (Can be opted only if Cumulative Bonus Booster Optional Cover is not opted)</div>		Not Available
<div><input type="checkbox"/> Premium Management Cover</div>		Not Available
<div><input type="checkbox"/> Women Care</div>	Not Available	Not Available
<div><div><input type="checkbox"/> Deductible<div><div><input type="checkbox"/> ₹ 50000</div><div><input type="checkbox"/> ₹ 1 Lac</div><div><input type="checkbox"/> ₹ 2 Lacs</div><div><input type="checkbox"/> ₹ 3 Lacs</div><div><input type="checkbox"/> ₹ 4 Lacs</div><div><input type="checkbox"/> ₹ 5 Lacs</div></div></div></div>	Not Available	<div><div><input type="checkbox"/> Deductible<div><div><input type="checkbox"/> ₹ 10000</div><div><input type="checkbox"/> ₹ 2 Lac</div><div><input type="checkbox"/> ₹ 25000</div><div><input type="checkbox"/> ₹ 3 Lacs</div><div><input type="checkbox"/> ₹ 50000</div><div><input type="checkbox"/> ₹ 4 Lacs</div><div><input type="checkbox"/> ₹ 1 Lacs</div><div><input type="checkbox"/> ₹ 5 Lacs</div></div></div></div>

Zone of Cover: (Please tick against your Zone):

<input type="checkbox"/> Zone I	<input type="checkbox"/> Zone II	<input type="checkbox"/> Zone III
<input type="checkbox"/> I would like to upgrade to Zone 1 and waive off Zonal Co-payment		

Zone I: Delhi & NCR. Districts in Gujarat: Ahmedabad, Gandhinagar, Surat, Vadodara.Districts in Maharashtra: Mumbai, Thane, Navi Mumbai.Districts in Andhra Pradesh /Telangana: Hyderabad, Khammam, Kothagudem, Hanamkonda, Warangal. Districts in Uttar Pradesh: Mathura, Jyotiba Fule Nagar (Amroha), Aligarh. Districts in Punjab: Amritsar, Gurdaspur.Others: Kolkata, Rewari, Jind, Jhunjhunu, Patna.

Zone II: Rest of the Bihar State Districts in Andhra Pradesh / Telangana: Ananthapur, Bapatla, Gadwal, Guntur, Jagtial, Kamareddy,Karimnagar,Kurnool,Mahabubnagar, Mancherial, Medak, Nalgonda, Nellore, Nizamabad, Peddapalli, Rangareddy , Suryapet, Wanaparthy.Districts in Punjab: Rupnagar (Ropar), Ludhiana, Fatehgarh Sahib, Mohali, Patiala. Districts in Maharashtra: Ahmednagar, Akola, Beed, Buldhana, Jalna, Latur, Nashik, Palghar, Pune, Raigad.Districts in Uttar Pradesh: Banda, Fatehpur, Kanpur.Others: Chennai, Bangalore, Wayanad, Chandigarh, Panchkula, Bokaro, Dhanbad.

Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II
(Note - Some areas (pin-codes) that are in the immediate vicinity of the districts mentioned in the zone definition above are classified in the respective zones of those districts)
Default zone of cover will be based on Proposer's city-location pin code as mentioned in CKYC document.

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.

IV. MEDICAL AND LIFESTYLE INFORMATION*:

"Please note: Proposed Insured(s) under the product having a history of Diabetes and/or Hypertension for 25 years or more, shall not be eligible to buy this product."

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

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

1	Gout / Hyperuricemia (high uric acid in blood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Shoulder Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Spondylitis / Spondylosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Prolapse of Inter-vertebral disc (disc prolapse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Total Knee Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Total Hip Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Any other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x	Ear, nose, eye and throat disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	Otitis-media (middle ear infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Nasal Polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Deviated Nasal Septum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Pharyngitis (throat infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Vocal Cord Nodule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Any other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xi	Genito-urinary and Gynaecological disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	Kidney / bladder stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Recurrent Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Stricture Urethra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Cytitis/ Infection of urinary bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Benign Hypertrophy of Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Hydrocele	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Torsion of testes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Phimosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Breast lump / Cyst / abscess	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Ovarian cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Fibroid Uterus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Menstrual disorder / irregular or excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Bartholin's abscess / cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Vaginal prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Cervical polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Any other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xii	Blood and related disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Thalassaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	HIV / AIDS (Acquired Immuno-deficiency syndrome)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xiii	Skin disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Urticaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Cyst/ lump/ growth / polyp / tumour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Any other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xiv	Any other condition/ illness/ disorder/ surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
A	Smoke	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	Since how long does the applicant smoke								
a	<=20 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	>20 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	Tobacco	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	How many Pan masala / gutka packets does the applicant has in a day								
a	1-3 packets/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	4-6 packets/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	>6 packets/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C	Alcohol	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	How frequently does the applicant consume alcohol								
a	1-3 days/ week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	3-6 days / week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
For Personal Accident Cover (if Opted)		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q7	Does any proposed to be insured suffer from any terminal illness, seizure disorders or any disease/deformity affecting or restricting mobility, sight, hearing or speech?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Q8	Does any proposed to be insured's occupation or nature of duties require them to be a part of armed forces, expose them to hazardous substances/chemicals ^{***} or hazardous activities ^{**}	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

^{***}Hazardous substance/ chemicals: Substances, chemicals, mixtures which pose a significant risk to health and safety (Inflammable or combustibles, carcinogens, Allergens, Irritants, asphyxiants, toxic gases, pesticides, poisonous substances, compressed gases, explosives etc).
^{**}Hazardous activities: Working underground, Flight cabin crew, crew on river/sea faring vessels, manual work at heights (line layers, window cleaners etc), Working with high voltage, working with high heat or high pressure gases, Manual labourers/workers, driving commercial heavy vehicles.

V. ADDITIONAL MEDICAL INFORMATION:

If answers to Q2, Q7 and Q8 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								

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)

VI. 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												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 2												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 3												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 4												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 5												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 6												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 7												<input type="checkbox"/> YES <input type="checkbox"/> NO
Insured 8												<input type="checkbox"/> YES <input type="checkbox"/> NO

VII. 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.

VIII. 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 BASBA^s

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

☐ I hereby give my consent and authorize my Bank to block the premium amount payable and debit the same from my Account under Bima-ASBA* facility on acceptance of my Proposal for Insurance by ManipalCigna Health Insurance Company Limited.

BASBA/ Bima-ASBA - Bima Applications Supported by Blocked Amount

Instrument / Transaction Number : Instrument/Transaction Date: DD MM YYYY

Instrument /Transaction Amount :

Bank Name :

Payment to be collected only from Proposers Card/Bank Account

[illegible]

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 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.

Further, 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.

Signature of Proposer *: _____

Date:

D	D	M	M	Y	Y	Y	Y
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Place: _____

(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)

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: **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)

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
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Place: _____ **Signature of Agent:**

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1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 prospectus 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.

Received from Ms / Mrs / Mr	
a sum of ₹	through Cash/Cheque/DD/Credit Card/Debit Card No/Others. 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 policy 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 realized.

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.