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

ManipalCigna Health Insurance

MANIPALCIGNA PROHEALTH SELECT

Migration Form

PART I

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

Email:

City (District): State:

Pin code:

4. Details of existing insurer:
   - i. Name of the product:
   - ii. Sum Insured:
   - iii. Cumulative Bonus:
   - iv. Add-ons/riders taken:
   - v. Policy number:
5. Details of the proposed insurance
   - i. Name of the product proposed/intend to take:
   - ii. Sum Insured Proposed:
   - iii. Whether Cumulative Bonus to be converted to an enhanced sum insured:
6. No. of family members to be included in the policy to be migrated:

Enclosure: Photocopy of the existing policy documents

Date: DD MM YYYY

Signature of the Policy Holder

PART II

1.	Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy	(Please indicate Yes / No) **YES** ☐ **NO** ☐
2.	Has any of the insured been diagnosed or suspected to have any health issue except common cold, flu, fever, loose motions post issuance of previous policy?	(Please indicate Yes / No) **YES** ☐ **NO** ☐

ow:

Please give written consent to the declaration below:

Declaration

- I am aware that waiting periods, exclusions and other conditions will be applicable in line with the 'Migration' guidelines prescribed by the Insurance Regulatory and Development Authority of India.
- 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.

PART III

Please fill the following details with respect to claims in health insurance policy(ies) currently held with the Company (Individual or Group)?

Insured	Policy Number	Type of Policy e.g. Mediclaim, PA, CI, Hospital Cash	Claim Number	Claimed Amount	Ailment
Insured 1					
Insured 2					
Insured 3					
Insured 4					
Insured 5					

Please Note: Migration and issuance will be subject to complete UW /medical assessment and basis UW guidelines.