ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited) CIN U66000MH2012PLC227948 | IRDAI Reg. No. 151 Reg. Office: 401/402, 4th Floor, Raheja Titanium, off. Western Express Highway, Goregaon (East), Mumbai- 400 063 | Toll free number – 1800-102-4462 Website address -www.manipalcigna.com | E-mail: servicesupport@manipalcigna.com



ANNEXURE e – INSURANCE ACCOUNT FORM

A) Ple	ase provid	de the	belo	ow d	letai	s o	f the	ma	ain a	applio	cant	(p	ropo	ose	er)																					
PAN :															UID																					
Email :																																				
B) Authorized Representative* Details (Mandatory)																																				
Name :																																				
DOB: DDMMYYYY								Gender: Male						Female					Relationship with eIA applicant :																	
Email ID :																			ſ	Mobile :																
Addres	s:																																			
	Landm	ark:																			1										T					
	City*:																			Tow	'n ([Dis	trict):							T					
	State*:																										Pin	Со	de*:		T					
Repres deceas	An Authorized Representative has only access rights to the e-Insurance account in the event of demise of the policy holder. The Authorized Representative would only to act as a facilitator and is not entitled to receive any policy benefits unless designated as a 'nominee' or 'assignee' by the deceased policy holder. C) I wish to notify Authorized Representative about his/her appointment Yes No																																			
Declara	ation:																																			
The rules and regulations of Insurance Regulatory and Development Authority of India & Insurance Repository pertaining to an e-Insurance Account which are in force now have been read by me and I have understood the same and I agree to abide by and to be bound by the rules as are in force from time to time for such e-Insurance Account. I hereby declare that the particulars given herein are true, correct and complete to the best of my knowledge and belief, the documents submitted along with this application are genuine and I am not making this application for the purpose of contravention of any Act, Rules, Regulations or any statute or legislation or any Notifications, Directions issued by any governmental or statutory authority from time to time. I authorise the Insurance Repository to send any policy and account related information through email and SMS on the contact details given by me. In case of any physical policies being issued by the Insurance Company from whom I obtain an e-policy, the address in the e-Insurance Account shall override the address provided for the physical policies. I understand that all the communication relating to any physical/ e-policy will be sent to the address registered with the Insurance Repository.																																				
acts on the san	I agree to inform the Repository of any changes in the details mentioned in this form and in case of delay the said repository shall not be liable in case it acts on the said information which has not been updated. Further, in case I update the details with the Insurance Company, I authorise them to submit the same to you for update in the e-Insurance Account and the said update will be applicable to all policies of any insurer that I hold/ will hold in the said account. I authorise the Repository to pass on the information to any Insurance Company that I have approached for availing of insurance cover.															omit																				
	r agree tha ation and fu				islea	adin	g inf	form	natio	on giv	ven	by	me	or s	suppi	essi	on o	of a	ny	mate	erial	l fa	ct w	/ill ı	ren	der	my	e-l	nsu	rand	ж А	١cc	oun	t lia	able	for
provide	y authorise ed by me to ng all chang	the res	spec	tive	Insu	ran	ce Ĉ	om	pani	ies a	nd/	orto	o the	eir a	autho	rised																				
Ihereb	y agree to p	orovide	any	/add	ditior	nal ir	nforn	nati	on/	docı	ıme	ntat	tion	tha	tmay	/bei	requ	lirec	db	y the	Aut	hor	rise	dP	arti	es,	in c	onr	ecti	onv	with	thi	is ap	plic	catio	on.
	y confirm t ice Reposi											ben	ing a	app	olicat	on a	nd l	l ha	ve	not a	appl	ied	to f	the	sa	me	Ins	urai	nce	Rep	osi	tor	y or	an	y ot	her

I would like to receive my insurance policy and all the information related to the proposed insurance policy through Insurance Repository.

Name of eIA Holder:																		
Date: D D M M	ΥY	ΎΥ	Y							Si	gnat	ure:						