**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:** servicesupport@manipalcigna.com

ManipalCigna Health Insurance

Proposal Form No.: _____

**FOR OFFICE USE**

Branch Name*: _____ Branch Code: _____ Business Type: Urban/ Social/ Rural

Intermediary Name: _____ Sourcing Department: _____ Intermediary Code*: Agent Code / Broker Code / CA Code

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

# MANIPALCIGNA GLOBAL HEALTH GROUP POLICY PROPOSAL FORM

1. This form should be filled by the Corporate or any person authorised by the Corporate to sign on their behalf.
2. Please fill the form in BLOCK LETTERS.
3. Please submit the proposal form in original, photo copies will not be accepted by the Company.
4. Kindly contact the Company's Office for any doubt or clarification on the Proposal Form.

Note: The liability of the Company does not commence until this proposal is accepted by the Company and premium received.

## 1. PROPOSER (CORPORATE) DETAILS:

All invoices will be raised to the following address and addressed to the Principle contact person mentioned below

Proposer Name* : First* Middle Last*

Principle Contact Person Name:

Types of Business:

Correspondence Address: Block No./ Flat No.: Floor No.: Building Name:

Street Name: Locality:

Landmark:

City: Town (District):

State*: Pin Code*:

Country:

Contact Number* : Landline: Mobile Number*:

E-mail Address :

PAN No. / TAN No. : <For Premium above Rs 50,000>

Aadhaar Card No. : Customer GSTIN No. (if any):

Period of Insurance From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Please state whether all eligible employees/families, members/families of the Group / Association / Institution / Corporate Body are proposed for Insurance? Yes ☐ No ☐

Please state the Total Number of Employees/ Members to be covered (including families/ dependents wherever covered):

## 2. INSURED DETAILS:

**Is the Address of insured different from that of the Proposer?** ☐ **Yes** ☐ **No**

**If Yes please provide address:**

Please provide details of Insured Persons and of benefit and coverage required (Attach separate sheet with the following data elements)

| Details | Insured 1 | Insured 2 |
|---|---|---|
| Unique identification No./ Employee No./ Membership No. | | |
| Name of Insured member | | |
| Relationship with the Proposer | | |
| Relationship of the family members with the Employee/ Member | | |
| Date of Birth | | |
| Gender | | |
| Height | | |
| Weight | | |
| Nationality | | |

ManipalCigna Global Health Group Policy | UIN: CTTHLGP20018V021920 | URN: 2019/CGHB/V1.01 | May 2019

| | | |
|---|---|---|
| Earning/Non- earning | | |
| Gainful Annual Income | | |
| Passport No. | | |
| Passport Expiry Date | | |
| Profession/ Nature of Duty/ Occupation | | |
| Designation/ Category/ Position | | |
| Out of Country Location | | |
| Date of Enrollment / Joining | | |
| Trip Start date/ Coverage Commencement Date | | |
| Trip End Date | | |
| No. of Travel days | | |
| City of origin | | |
| Place of residence | | |
| Area/s of Cover | | |
| Overseas Address | | |
| Visa Type (Immigrant/ Non-immigrant) | | |
| Visa Validity (From – To) | | |
| Purpose of Visit (Business/ Holiday/ Studies/ Others (specify)) | | |
| Email ID | | |
| Mobile No. | | |
| Pre-existing Diseases | | |
| << Any Medical information which you may want insurer to know?>> | | |
| Plan/ Base Cover/s | | |
| Sum Insured | | |
| Deductible and other limits, Sub Limits and condition | | |
| Optional Covers | | |
| Sum Insured | | |
| Deductible and other limits, Sub Limits and condition | | |
| Nominee Name and Relationship with Insured# | | |
| Nominee: Date of birth | | |

# A Minor should not be declared as nominee.

| **MEDICAL & LIFE STYLE INFORMATION:**<br>(The list is indicative and questions may be added or deleted depending on group basis UW requirement) | Insured 1 | Insured 2 |
|---|---|---|
| Are You suffering from or have You ever suffered from any of the following (please encircle): musculoskeletal diseases, arthritis, disorders of the spinal cord or vertebral column like slipped disc, osteoporosis, disease of bones/ joints etc, circulatory disorder, high blood pressure, heart condition, varicose veins, etc, cancer of any kind, tumor, cyst, ulcer, endocrine disorders, diabetes, thyroid, etc, digestive or gastrointestinal digestive or gastrointestinal disorders, liver disorder, hernia of any kind, hemorrhoids, fistula, hematological (blood) disorder, mental / Psychiatric condition, nervous disorder, fainting episode, blackouts, fits, paralysis of any kind, respiratory disorder, kidney or urinary tract disorder, ENT, eye, dental, allergies, skin disorder, gynecological and breast disorder, alcohol or drug abuse or any diseases or injury requiring surgical or medical treatment. | Yes ☐ No ☐<br>If Your answer is 'yes' to any of the above, please provide details:<br>_____<br>_____<br>_____<br>_____ | Yes ☐ No ☐<br>If Your answer is 'yes' to any of the above, please provide details:<br>_____<br>_____<br>_____<br>_____ |
| Do you have any physical deformity, any pre-existing illness / disease / injury / disability / physical or mental illness (psychiatric, sleep disorders) / or any condition that may affect mobility / sight / hearing / speech? | Yes ☐ No ☐<br>If Your answer is 'yes' to any of the above, please provide details:<br>_____<br>_____ | Yes ☐ No ☐<br>If Your answer is 'yes' to any of the above, please provide details:<br>_____<br>_____ |
| Have you ever been hospitalized for treatment/ observation/ /recommended to take investigation/ surgery? | Yes ☐ No ☐<br>If Your answer is 'yes' to any of the above, please provide details:<br>_____<br>_____ | Yes ☐ No ☐<br>If Your answer is 'yes' to any of the above, please provide details:<br>_____<br>_____ |
| Are you currently or in past were on medication? | Yes ☐ No ☐<br>If Your answer is 'yes' to any of the above, please provide details:<br>_____<br>_____ | Yes ☐ No ☐<br>If Your answer is 'yes' to any of the above, please provide details:<br>_____<br>_____ |

| | | |
|---|---|---|
| Have you suffered from any illness or had an Accident in the preceding 12 months? | Yes ☐ No ☐<br>If Your answer is 'yes' to any of the above, please provide details:<br>_____<br>_____<br>_____ | Yes ☐ No ☐<br>If Your answer is 'yes' to any of the above, please provide details:<br>_____<br>_____<br>_____ |
| Have you recently (within 60 days) taken any health check-up? | Yes ☐ No ☐<br>If Your answer is 'yes' please attach report.<br>_____<br>_____<br>_____ | Yes ☐ No ☐<br>If Your answer is 'yes' please attach report.<br>_____<br>_____<br>_____ |
| Has any application for life or health ever been declined, postponed, loaded or been made subject to any special conditions by the company or any insurance company? | Yes ☐ No ☐<br>If Your answer is 'yes' please attach report.<br>_____<br>_____<br>_____ | Yes ☐ No ☐<br>If Your answer is 'yes' please attach report.<br>_____<br>_____<br>_____ |

## 3. PLAN DETAILS:

Note: Additional insurances (optional covers) can be purchased only in addition to a core plan and not separately. All elements can be chosen per expat group. In case of multiple plans/sum insured requirements please mention the details against each member/family in the attached format.

Please select the required plan(s) (if multiple plans are required for different sets of employees, please fill the relevant plan in the Insured Details section):

| | |
|---|---|
| Plan Name | <<Plan name with Plan specific criteria- SI, Covers, Eligibility, etc>> |
| Policy Tenure | 1 Year |
| No. of Travel days <<For corporate Policy>> | |
| Cover Type | <<Individual >> |
| Sum Insured/s | <<Currency>> <<Amount>> |
| Area/s of Cover | << Area of Cover>> |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Base Cover/s** (Sum Insured, Sub Limit, Deductible/ Sub-limit/ Waiting Period/ Other Limits & Conditions) | Name of the Cover | Sum Insured | Aggregate Limit (if opted) | Sub-limits/ Sub- options | Deductible/s | Co-pay | Other Limits & Conditions |
| | | | | | | | |
| **Optional Cover/s** (Sum Insured, Sub Limit, Deductible/ Sub-limit/ Waiting Period/ Other Limits & Conditions) | Name of the Cover | Sum Insured | Aggregate Limit (if opted) | Sub-limits/ Sub- options | Deductible/s | Co-pay | Other Limits & Conditions |
| | | | | | | | |

| Sr. No. | **Name of the Waiting Period** <<as applicable>> | **Waiting Period** <<as opted>> |
|---|---|---|
| | | |
| | | |
| | | |

## 4. DETAILS OF PREVIOUS INSURER(S) (If renewal):

Are your employees/members at present insured under any Domestic / International Health Insurance? Yes ☐ No ☐

If 'Yes' Please provide the details of insurer, type of policy with coverage & sum insured-(attach additional sheet if required)

Name of Insurer:

Policy Number :

Expiring Terms of cover:

Period of Insurance:

Premium paid:

Claim details: (Please attach separate sheet providing complete details of claims with individual claim records)

Incurred Claims Ratio:

Note: Ensure that the information in this form material for assumption of risk is accurate and complete as inaccuracy or non-disclosure of the requested information or other material facts could preclude recovery of any claim under the policy.

## 5. Premium payment details (Please provide the details of premium payment):

Premium Amount (INR): _____

Payment Option (please tick (✓)): ☐ Cheque ☐ DD ☐ Other (Specify) _____

Amount in words _____ ☐ Fund Transfer

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

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

Instrument No.: _____ Instrument Date: D D M M Y Y Y Y

Instrument Amount: _____

Bank Name: _____

Name of Premium Payer: _____

## 6. DECLARATION & AUTHORIZATION:

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 authorized 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 any time 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.

**Date:** D D M M Y Y Y Y

**Time:** _____ **Place:** _____

**Signature of Proposer**

## 7. INTERMEDIARY DECLARATION:

I, _____(Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized 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 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 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 **Time:**_____ **Place:**_____

**Signature of Corporate 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 out or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.
2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to 10 lakh rupees.

**INSURANCE IS A SUBJECT MATTER OF SOLICITATION**

Note: Proposal form shall be used for group policy and it shall be customized as per the coverage and benefits offered under the product for the group as per their requirement