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

Manipal Cigna

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Photograph of Insured 5	Photograph Insured (Photograph of Insured 7			Photograph Insured 8					
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This form is verified by way of a One Time Password (OTP) sent to the mobile number XXXXXX1234; The details provided in this proposal include the information provided at the Quote stage.

Wou	Ild you like to subscribe	to important	alert on	Whatsapp?	Yes	No							
Wou	Ild you like to go digital a	and receive a	all policy	related inform	nation in	soft copy/	/via email only?	Yes	🗸 No	(please tick N	o if you want to	opt out)	
Occ	upation* : 0	Government	Service	e Priva	te Service	e	Self Employed		Othe	rs			
Ann	ual Income* : I	Up to ₹50,0	00	₹5 to	10 Lacs		₹15 to 20 Lacs						
	₹	₹50,000 to ₹	5 Lacs	₹10 t	o 15 Lacs	S	Above ₹20 Lac	CS					
Edu	cational Qualification* : L	ess than cla	ass X	Class X		Class X	(II Gradu	ate	Post Gra	duate	Professional	Degree	
Cus	tomer Goods & Service ⁻	Tax Identifica	ation Nu	Imber (if any):									
Res	idential status* :	Indian	NRI If I	NRI, Please m	nention co	ountry			Others	(Please specify	y)		
PAN	Card Number* :												
Forr	n 60* (only in case wher	e PAN numb	per is no	t available) Y	es	No							
	tity Document Type : Aa			Driving Lic		Pass	sport Va	oter's ID o	ard	Others			
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(Plea last f	se mention only our digits of your aar or VID)					2000							
СКЛ	'C number :						EIA number	:					
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Day	ou wish to assign a Car	eqiver for vo		y/ies: Yes	Nc		If Vee in	lease pro	wide:				
Nan				T N A N	+		·			S U F	R N A M	1 E*	
	ile number* :					IVI			Proposer:				
Age	(in Years) :						Email id						
-	giver can be a close family me	mber who wou	ld take cai	re of the Insured I	Person in ar	ny kind of he			gency or plann	ned. The Caregiver r	might not be the	SOS contact	t.
	se provide the details to enabl					-					-		
	OMINEE DETAILS:												
	e Nominee same as Ca	regiver (if pr	ovided a	above)? Yes	No	l If	No, please prov	/ide Nom	inee details	3.			
	ninee Name	:	FI		NAN	/ E*	MID	DLE	ENA				E
Rel	ationship with Proposer	:								N	lominee Age	:	
	C number of Nominee	:	t duo und	or the Policy shall	l bocomo n	avable to the	o nominoo as nor th	o 'Nominat	ion' clauso dot	fined by the IRDAL a	and the receipt of	of the proceed	le by such
nom	nee would be sufficient discha	rge to the Com	pany. For	all other persons								ine proceed	is by such
	oointee details: (Require	ed only if no	minee is	s a minor)									
	ointee Name	·											
	ationship with Nominee	: Annointee									Age	•	
L	POLICY/PLAN DET												
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Ie	nure*: 1 Year						eriod: From D instrument date/ pre			Y Y at		Hrs	
INS	URED DETAILS*:(Su	Im Insured only	for individ	dual cover)									
Sr No.	Name (First*,Middle, Last*)	Gender* (M/F/O)	DOB*	Relationship with	Height* (Cms)	Weight* (Kgs)	Occupation/ Industry	City*	Gainful Annual	Sum Insured*	Insured	If PEP/	с-күс
140.	(i list , widdle, East)	(1007)		Proposer*	(0113)	(1(g3)	Type/ Nature of Job*		Income*		Address If Different	Relatives of PEP [^]	number
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1													
2													
3													
5													
4													
5													
6													
7													
0													
8													

APolitically exposed person
This form is verified by way of a One Time Password (OTP) sent to the mobile number XXXXXX1234; The details provided in this proposal include the information provided at the Quote stage.

All insured Indian national and Indian residents? Yes	No	

If No, Please mention country

Note:

Saral Suraksha Bima, ManipalCigna: The minimum entry age under this policy is 18 years and maximum age at entry is 70 years. Dependent child/children shall be covered from the age of 3 months to 25 years.

1. Saral Surkasha Bima, ManipalCigna Base cover includes Death, Permanent Total Disablement and Permanent Partial Disablement

Plan Type*:	Optional Covers
Individual Family cover	1. Temporary Total Disablement (available only to earning member)
In case of Family Option - Sum Insured for Spouse will be limited to 60%	2. Hospitalisation Expenses due to Accident
of the Proposer and for Dependents will be limited to 30% of the Proposer.	3. Education Grant

Applicable Discounts:

a.	Family Discount of 1	% for covering more than 2 or more individuals with individual Sum Insured under the same poli	cv.
u.	r anny Discount of the	to be configured and 2 of more manuadals with manuadal out in moured and of the same po	

b. Online Renewal Discount of 3% discount on the renewal premium, if the renewal premium is received through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card)

c. worksite marketing D	iscount vvorksite Cod	e:	Employee Id:	
Premium payment mode:	Monthly [^]	Quarterly	Halfyearly	Yearly
^2 months premium to be paid in advan	ce and instalment/renewal pre	mium payment through NACH	l or standing instruction (where a	payment is made either by direct debit of bank account or credit card)

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. This is applicable only where medical examination or underwriting is not required. In case a medical examination is to be done or an underwriting approval is required, the Policy shall commence on or after the date of approval by underwriter or the date of receipt of any additional premium, whichever is later.

IV. MEDICAL AND LIFESTYLE INFORMATION*:

Fo	r Saral Suraksha Bima, ManipalCigna	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8
Q1	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?	YES	YES	YES NO	YES	YES NO	YES NO	YES	YES NO
Q2	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 ["]	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES

⁴⁶Hazardous 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 above questions 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*:

VI. PREVIOUS/ CURRENT INSURANCE DETAILS:

Pease 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		laim Deta		Bonus	ulative Earned			
							Claim Number	Claimed Amount	Ailment	%	Amount	(Y – Yes /	N – No)	
Insured 1												YES	NO	
Insured 2												YES	NO	
Insured 3												YES	NO	
Insured 4												YES	NO	
Insured 5												YES	NO	
Insured 6												YES	NO	
Insured 7												YES	NO	
Insured 8												YES	NO	

For active policies, please attach policy copies.

Insured wise information required with all the above information in Previous/ Current Insurance Details.

VII. PAYMENT DETAILS*:

Premium Paid by	:	<first></first>	>	<middle></middle>	<last></last>	Relationship to Proposer :	
Premium Amount	:			ir	n Words		
Signature	:						
Payment Option:	Cheque		Demand Draft	Pay Order	Credit Card	Debit Card	Cash
For Cheque / DD / Proposal form No.	Credit Car	d/ Debit	Card/ PO/ Others (Pl	ease specify)	(Payable in favour	of "ManipalCigna Health Insu	rance Company Limited" -
Instrument / Transa	ction Numb	er	-		Instrument/Transactio	on Date: D D M M	YYYY
Instrument /Transad	ction Amour	nt	:				
Bank Name			:				
Payment to be collected	only from Pro	posers Ca	rd/Bank Account				

VIII. BANK ACCOUNT DETAILS*:

Mandatory details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account.

Please select any one of the below options as applicable.

Bank details as per premium cheque to be used for electronic fund transfer.

Bank account details as mentioned on the cheque being submitted along with the Proposal Form towards premium payment for insurance Policy should be used by the Company for electronic fund transfer as mode of payment.

Please fill the below table if the premium payment cheque does not have all the details required for electronic fund transfer.

No existing Bank Account.

I do not have any existing bank account. I agree to open a bank account and provide my bank account details to the Company for electronic fund transfer as mode of payment. I shall provide these details before renewal of my insurance policy or before any payment becomes due in relation to my insurance policy (whichever is earlier). I understand that as per regulatory requirement, Company shall process any payment in relation to my insurance policy only through electronic fund transfer after receipt of aforesaid pending bank details from me.

Cancelled Cheque submitted for Refund Processing

Bank account details as provided below and for which I am submitting a cancelled cheque, should be used by the Company for electronic fund transfer as mode of payment. (Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly). I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy.

articulars of Bank Account*:
ccount Number:
SC/MICR Code:
ame of the Bank:
ccount Holder Name:
gree and undertake to intimate in writing to ManipalCigna Health Insurance Co. Ltd about any change in bank account details. I also hereby certify that the particulars rnished above are correct to the best of my knowledge.
SCLAIMER: ManipalCigna shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including thout limitation- failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by ustomer/Policy Holder.
oresaid NEFT transaction shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms d conditions related to NEFT facility. ManipalCigna shall be indemnified against any loss/damage/claims caused to ManipalCigna in carrying out your aforesaid NEFT structions. structions: It is important for these electronic payment systems that the Policy Holder's name in the Policy must exactly match with the name in the Bank Account records/details given above. In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required. The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFS Code, which is applicable for NEFT only. (a number allotted to each participating banks branch) of the branch where the funds need to be transferred. Cancelled cheque should be attached along with the NEFT format. In case cancelled blank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required NEFT Form needs to be complete in all respect.
ate: D M M Y Y Y Signature of Proposer*:
DECLARATION & AUTHORISATION*: 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 omplete in all respects to the best of my knowledge and that I/We am/are authorised to propose on behalf of these other persons.
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

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.

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.

I hereby agree to the Terms and Conditions of the policy/ies

Date: D D M M Y Y Y Y	Place:	Signature:	

*

X. VERNACULAR DECLARATION:

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

Date:	D	D		\mathbb{N}	\mathbb{N}		Y	Y	Y	Y	Place:
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Signature:

XI. ADVISOR / INTERMEDIARY DECLARATION*:

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

Signature of Agent:

Section 41 of Insurance Act 1938 (Prohibition of rebates):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Place:

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ACKNOWLEDGEMENT: (Tear Off)										
Received from Ms / Mrs / Mr										
a sum of ₹through Cash/Cheque/DD/Credit Card/Debit Card No	against your proposal forPolicy.									
Signature of ManipalCigna official / Intermediary:	Date:									
ManipalCigna official / Intermediary Name:										
Time: Place: 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 the product and the Company shall have no liability to make any payment if premium is not received by ManipalCigna Health Insurance Company Limited in full and in time, or is not realised.										
Should you choose to pay premium by Cash, you are advised to do so only at the nearest ManipalCigna branch or its authorised collection points. Handing over cash to any Advisor/ Employee is solely at your own risk and the Company shall in no way be held responsible for any loss in this regard.										
If a proposal is not accepted, ManipalCigna Health Insurance Company Limited will inform you and refund any payment received from you without interest.										
Insurance is a subject matter of solicitation.										

This form is verified by way of a One Time Password (OTP) sent to the mobile number XXXXX1234; The details provided in this proposal include the information provided at the Quote stage.