

Proposal Form No.:

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
E-mail: customercare@manipalcigna.com CIN No.: U66000MH2012PLC227948



Grid of 8 boxes for photographs of insured persons, labeled Photograph of Insured 1 through 8.

FOR OFFICE USE ONLY

Form section for office use only containing fields for Branch Name, Intermediary Name, Business Type, Ops Tags, and Sub Intermediary Name/PAN.

Ref. A
Ref. B

SARAL SURAKSHA BIMA, MANIPALCIGNA 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.

Form section for Staff Rebate details including Name of the organization, Name of the Employee, and Employee ID.

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:

Form section for Proposer Details including Title, Date of Birth, Name, Permanent Address, Correspondence Address, Email Address, and Telephone Number(s).



All insured Indian national and Indian residents? Yes  No

If No, Please mention country \_\_\_\_\_

**Note:**

- Saral Suraksha Bima, ManiplaCigna: 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, ManiplaCigna Base cover includes Death, Permanent Total Disablement and Permanent Partial Disablement**

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

a. **Family Discount** of 15% for covering more than 2 or more individuals with individual Sum Insured under the same policy.

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 Discount** Worksite Code: \_\_\_\_\_ Employee id: \_\_\_\_\_

**Premium payment mode:**  Monthly^  Quarterly  Half yearly  Yearly

^2 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)

**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\*:**

For Saral Suraksha Bima, ManiplaCigna		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?	<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	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 <sup>#</sup> or hazardous activities <sup>**</sup>	<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

<sup>#</sup>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)

<sup>\*\*</sup>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:**

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. Medicaid, 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?  (Y – Yes / N – No)
							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

**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>	<Middle>	<Last>	Relationship to Proposer :	_____	
Premium Amount :	_____ in Words _____					
Signature :	_____					
<b>Payment Option:</b>	Cheque <input type="checkbox"/>	Demand Draft <input type="checkbox"/>	Pay Order <input type="checkbox"/>	Credit Card <input type="checkbox"/>	Debit Card <input type="checkbox"/>	Cash <input type="checkbox"/>
<b>For Cheque / DD / Credit Card/ Debit Card/ PO/ Others (Please specify)</b> _____ (Payable in favour of "ManipalCigna Health Insurance Company Limited" - Proposal form No. _____)						
Instrument / Transaction Number :	_____		Instrument/Transaction Date:	DD MM YYYY		
Instrument /Transaction Amount :	_____					
Bank Name :	_____					
Payment to be collected only from Proposers Card/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.



**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:

Place: \_\_\_\_\_

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:

Place: \_\_\_\_\_

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.



**ACKNOWLEDGEMENT: (Tear Off)**

Received from Ms / Mrs / Mr

a sum of ₹ \_\_\_\_\_ through Cash/Cheque/DD/Credit Card/Debit Card No. \_\_\_\_\_ 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 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.**