

MANIPALCIGNA SARVAH

Portability Form

PART I

| | | | | | | | |
|---|--|-----------------|--|-------------|--|---------------|--|
| 1. Name of the Policy Holder/ Insured (s): | | F I R S T | | M I D D L E | | S U R N A M E | |
| 2. Date of Birth: | | D D M M Y Y Y Y | | 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. Reason(s) for Portability: | | | | | | | |
| 7. No. of family members to be included in the policy to be ported: | | | | | | | |

Enclosure: Photocopy of the existing policy documents

Date: D D M M Y Y Y Y

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 <input type="checkbox"/> NO <input type="checkbox"/> |
|----|---|--|

If 'Yes', please give written consent to the declaration below:

Declaration

I am aware that the waiting period for the following disease(s)/treatment(s) is _____ days/ years more than the previous policy terms.
 I hereby agree to observe the additional waiting period for the following disease(s)/ treatment(s)

Signature of Policy Holder