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

ManipalCigna Health Insurance

Photograph of Insured 1

FOR OFFICE USE ONLY

Branch Name:	Branch Code:
Intermediary Name:	Intermediary Code: Agent Code / Broker Code / CA Code
Business Type: Urban /Social / Rural	
Ops Tags: Employee DMS Code: ManipalCigna Employee DMS Code	Partner Vertical Name: Partner Business Vertical Code
Partner Branch ID: Partner Branch Code	
Sub Intermediary Name:<<For POSP>> Sub Intermediary PAN:<<For POSP>>	Other Details:<<For POSP>>

Ref. A

Ref. B

Ref. C

SECUREHEALTH, MANIPALCIGNA
PROPOSAL FORM

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.

1. This Policy is specially designed for Persons with Disability, Mental Illness and Persons with HIV/ AIDS
   a. Persons with Disability shall be covered if 40% or more disability is certified by the Medical Board appointed by the government for certifying Disability as per Disability Act 2016.
2. Only Indian Nationals can be covered under this policy.
3. Only one policy can be purchased for this product across all Insurers.
4. 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.

For Staff Rebate# please provide: Name of the organization: _____

Name of the Employee: _____ Employee ID: _____

#(Applicable only if Proposer or any Insured person under the policy is employee of: ManipalCigna, Promoter group of ManipalCigna)

I. PROPOSER DETAILS*:

Title* : Mr. ☐ Mrs. ☐ Ms. ☐ Gender* : Male ☐ Female ☐ Others ☐ Tick if Employer is the Payor: ☐

Date of Birth* : D D M M Y Y Y Y Marital Status* : Married ☐ Single ☐ Others ☐

Name*(as in bank account): F I R S T N A M E* M I D D L E N A M E S U R N A M E*

Permanent Address*: (As per the KYC proof submitted):

Landmark:

City*: Town (District):

State*: Pin Code*:

Gram Panchayat:

Correspondence Address*:

If same as above, please tick here ☐

Landmark:

City* : Town (District):

State*: Pin Code*:

Gram Panchayat:

Email Address* : Address 1 Address 2

Telephone Number(s) : Mobile*: Residence (Optional):

Office(Optional):

Would you like to subscribe to important alert on Whatsapp? Yes ☐ No ☐

Policyholders have the option to access their Policy documents through DigiLocker with no additional charges.

To learn more about DigiLocker, please visit https://www.manipalcigna.com/video/

Would you prefer to receive all policy document digitally (via email/soft copy)?

☐ Yes (I would like to receive policy document digitally). ☐ No (I prefer to receive policy document in hard copy).

Occupation* : Government Service ☐ Private Service ☐ Self Employed ☐ Others ☐ _____

Annual Income* : Up to ₹50,000 ☐ ₹5 to ₹10 Lacs ☐ ₹15 to ₹20 Lacs ☐

₹50,000 to ₹5 Lacs ☐ ₹10 to ₹15 Lacs ☐ Above ₹20 Lacs ☐

Educational Qualification* : Less than class X ☐ Class X ☐ Class XII ☐ Graduate ☐ Post Graduate ☐ Professional Degree ☐

Customer Goods & Service Tax Identification Number (if any):

Residential status* : ☐ Indian ☐ NRI If NRI, Please mention country _____ ☐ Others (Please specify) _____

PAN Card Number* :

Form 60* (only in case where PAN number is not available) Yes ☐ No ☐

Identity Document Type : Aadhaar Card ☐ Driving License ☐ Passport ☐ Voter's ID card ☐ Others ☐

VID Number (Please mention only last four digits of your Aadhaar or VID)^^:

Document expiry date : D D M M Y Y Y Y

PEP or relative of PEP:

CKYC number :

EIA number:

Family Physician Details:

Name : FIRST NAME MIDDLE NAME SURNAME

Contact number :

Email id:

Address :

Do you wish to assign a Caregiver for your Policy/ies: Yes ☐ No ☐

Name* : FIRST NAME* MIDDLE NAME SURNAME*

Mobile number* :

Relationship with Proposer:

Age (in Years) :

Email id:

Caregiver can be a close family member who would take care of the Insured Person in any kind of health care event, whether emergency or planned. The Caregiver might not be the SOS contact.

^^Please provide the details to enable us to serve you better.

II. NOMINEE DETAILS*:

Is the Nominee same as Caregiver (if provided above)? ☐ Yes ☐ No

S. No.	Particulars	Nominee 1	Nominee 2	Nominee 3
1	Name			
2	Age			
3	Mobile No.			
4	Email ID			
5	Correspondence Address			
6	Permanent Address			
7	Relationship with Proposer			
8	Specify the percentage (%) of the claim amount payable to each nominee in the event of the policyholder's death. The total percentage of contribution across all the nominee must not exceed 100%			
9	Bank Details of Nominee Account No. IFSC/MICR Code Name of Bank Account Holder Name			
10	Appointee Details (Required only if nominee is a minor) Name Age# Mobile No. E-mail ID Relationship with Nominee			

As per recent regulatory mandate, nomination details are mandatory to be provided by the customers. Please provide your nominee details urgently by emailing us at customercare@manipalcigna.com; contacting us on 1800-102-4462, or visit our nearest branch.

In the event of death of the Proposer, any payment due under the Policy shall become payable to the nominee, as per the 'Nomination' clause defined by the IRDAI and the receipt of the proceeds by such nominee would be sufficient discharge to the Company. For all other persons covered under the Policy, the Proposer will be the nominee.

#A Minor should not be declared as Appointee.

III. POLICY/PLAN DETAILS*:

Tenure*: 1 Year ☐

Proposed Policy Period: From D D M M Y Y Y Y at : **Hrs**

(Must be on or later than instrument date/ premium payment date)

INSURED DETAILS*:

Sr No.	Name (First*,Middle,Last*)	Gender* (M/F/O)	DOB*	Relationship with Proposer*	ABHA Number^^^	Height* (Cms)	Weight* (Kgs)	Occupation/ Industry Type/ Nature of Job*	City*	Sum Insured*	Insured address if different from Proposer (Address, Gram Panchayat, City,Town (District), State/Pin Code)	If PEP/ Relatives of PEP^ (Y/N)	C-KYC number
1													

^Politically exposed person,

If PEP details are not provided, we will consider the same as "No".

^^^Please provide ABHA number (Ayushman Bharat Health Account number) for all the proposed Insured Persons. In case the ABHA number is not available for any Insured Person, you may request to create an ABHA number by visiting the web link: https://healthid.ndhm.gov.in/register

*Are all insured Indian National and Indian Residents? ☐ Yes ☐ No

If No, Please mention country _____

Plan Type* : Individual ☐	**Portability:** Yes ☐ No ☐ (If yes portability form to be completed and attached)	**Migration:** Yes ☐ No ☐ (If yes migration form to be completed and attached)
Sum Insured	☐ 4 Lacs ☐ 5 Lacs	
Coverage Opted	☐ Pre-existing HIV/AIDS with/without Disability ☐ Pre-existing Disability Only	

Applicable Discounts:

a. **Employee discount: 10%** discount on the premium

Premium payment mode: ☐ Monthly^ ☐ Quarterly ☐ Half yearly ☐ Single

^3 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).

IV. MEDICAL AND LIFESTYLE INFORMATION*:

I declare that the below statements are true and complete in all respects and all facts related to medical history have been disclosed. I understand that this declaration shall be the basis of decision by the Company to cover or not cover us under insurance. I also understand that failure to disclose all facts will result in claim rejection and / or policy cancellation.

	Medical questions	Insured 1
Q1	Do you or the Insured member suffer from any disability as per the listed conditions mentioned below: If Yes, please enclose Disability certificate mentioning percentage of disability (mandatory).	☐ YES ☐ NO
1	Blindness	
2	Muscular Dystrophy	
3	Low vision	
4	Chronic Neurological conditions	
5	Leprosy cured persons	
6	Specific Learning disabilities	
7	Hearing impairment (deaf and hard of hearing)	
8	Multiple Sclerosis	
9	Locomotor Disability	
10	Speech and language disability	
11	Dwarfism	
12	Thalassemia	
13	Intellectual Disability	
14	Haemophilia	
15	Mental Illness	
16	Sickle cell disease	
17	Autism Spectrum disorder	
18	Multiple Disabilities including deaf / blindness	
19	Cerebral Palsy	
20	Acid Attack victim	
21	Parkinson's disease	
	Please mention the percentage of disability	_____%
Q2	Do you or the Insured member suffer from HIV / AIDS. If Yes, Please enclose a recent certificate of your current CD4 count (within past 30 days)and provide the below details	☐ YES ☐ NO
i.	Current CD4 count	_____
ii.	Has your CD4 count gone below 500 in last 4 years	☐ YES ☐ NO
	If Yes, When and how many times	_____
iii.	Do you or the Insured member suffer from any other illness / disease related to / arising of / associated to HIV / AIDS	☐ YES ☐ NO
	If Yes, please give details	_____
Q3	Have you or the Insured member ever suffered from or taken treatment, or hospitalized or have been recommended to take investigations /medication/surgery or undergone a surgery for any medical conditions?	☐ YES ☐ NO

	If yes, please tick against the ailment / system listed below and provide details:	
i	Diabetes Mellitus	☐ YES ☐ NO
ii	Hypertension	☐ YES ☐ NO
iii	High Cholesterol	☐ YES ☐ NO
iv	Thyroid disorders	☐ YES ☐ NO
v	Heart and Lung disorders	☐ YES ☐ NO
vi	Digestive system disorders (Stomach, Liver and related organs)	☐ YES ☐ NO
vii	Brain and neurological disorders	☐ YES ☐ NO
viii	Other Endocrine (Hormonal) disorders	☐ YES ☐ NO
ix	Bone, joints and muscle disorders	☐ YES ☐ NO
x	Ear, nose, eye and throat disorders	☐ YES ☐ NO
xi	Genito-urinary (Kidney and related organs) and Gynaecological disorders	☐ YES ☐ NO
xii	Blood and related disorders	☐ YES ☐ NO
xiii	Skin disorders and/or any auto-immnue disorders	☐ YES ☐ NO
xiv	Any Cancer or tumor or lump or cyst	☐ YES ☐ NO
xv	Any other condition / illness / disorder / surgery	☐ YES ☐ NO
Habits and Lifestyle questions		**Insured 1**
Q4	Do you or the Insured member chew tobacco/ smoke/ consume alcohol? If Yes, please provide details:	☐ YES ☐ NO
A	Smoke	☐ YES ☐ NO
i	Since how long do you or the Insured member smoke	
a	<= 15 years	☐
b	> 15years	☐
ii	How many Cigarettes/bidi's do you or Insured member smoke in a day	
a	<=4/day	☐
b	>4/ day	☐
B	Tobacco	☐ YES ☐ NO
i	Since how long do you or the Insured member consume tobacco (Pan masala/Gutka)	
a	<= 15 years	☐
b	> 15years	☐
ii	How many Pan masala/ Gutka packets you or the Insured member have in a day	
a	<=3/day	☐
b	>3/ day	☐
C	Alcohol	☐ YES ☐ NO
i	Since how long do you or the Insured member consume alcohol	
a	<= 15 years	☐
b	> 15years	☐
ii	How frequently do you or the Insured member consume alcohol	
a	<=3/week	☐
b	>3/week	☐

Additional Medical Information

To be filled by you or the Insured member who have answered "Yes" to the above medical question (Q3). Please provide complete details of the illness/treatment in respect of the particular applicant.		**Insured 1**
i.	Exact Diagnosis - To be picked up from the medical condition chosen	
ii.	Year of diagnosis-Year to be picked from Calendar	
iii.	Treatment taken: Surgical/Medical/No treatment/Defaulter (left treatment on own)	
iv.	Current status - Cured / On treatment / Pending surgery or treatment	
v.	Complications/ Recurrences - Yes/No	
vi.	Last consultation date-"Month/Year" to be picked from Calendar	
vii.	Histo-Pathology Examination Report (only for surgical) - No abnormality, Malignancy/borderline malignancy/Tuberculosis	

V. PREVIOUS 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. Mediclaim, 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?
							Claim Number	Claimed Amount	Ailment	%	Amount	
Insured 1												☐ YES ☐ NO

Do you have the same policy (For Persons with Disabilities (PWD), Persons afflicted with HIV/AIDS, and those with Mental Illness) from any one or other Insurer?

If Yes, please share details below: ☐ **Yes** ☐ **No**

Insured	Policy No.	Insurer Name	From Date	To Date	Sum Insured	Claim Details		
						Claim Number	Claimed Amount	Ailment
Insured 1								

VI. Current Insurance Details

In the unfortunate event of claim, the below information will facilitate Us, in case you have chosen Us as a Primary insurer to coordinate with other insurers to ensure the hassle free settlement of your claim as per the applicable policy terms and conditions.

Please fill the following details with respect to health indemnity insurance policies(s) currently with any other insurance company?

Insured	Policy No	Insurer Name	From Date	To Date	Sum Insured	Cumulative Bonus Earned	
						%	Amount
Insured 1							
Insured 2							
Insured 3							
Insured 4							
Insured 5							

For active policies, please attach policy copies.
Insured wise information required with all the above information in Current Insurance Details

VII. PAYMENT DETAILS*:

Premium Paid by : <First> <Middle> <Last> Relationship to Proposer : _____

Premium Amount : _____ in Words _____

Signature : _____

Payment Option: Cheque ☐ Demand Draft ☐ Pay Order ☐ Credit Card ☐ Debit Card ☐ Cash ☐ BASBA[$] ☐

For Cheque / DD / Credit Card/ Debit Card/ PO/ Others (Please specify) _____ (Payable in favour of "ManipalCigna Health Insurance Company Limited" - Proposal form No. _____)

[$] ☐ I hereby give my consent and authorize my Bank to block the premium amount payable and debit the same from my Account under Bima-ASBA* facility on acceptance of my Proposal for Insurance by ManipalCigna Health Insurance Company Limited.

BASBA/ Bima-ASBA - Bima Applications Supported by Blocked Amount

Instrument / Transaction Number : _____ Instrument/Transaction Date: D D M M Y Y Y Y

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/refund.**
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.

Particulars of Bank Account*:

Account Number:	
IFSC / MICR Code:	
Name of the Bank:	
Account Holder Name:	

I agree 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 furnished above are correct to the best of my knowledge.

DISCLAIMER: ManipalCigna shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation- failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder.

Aforesaid NEFT transaction shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. ManipalCigna shall be indemnified against any loss/damage/claims caused to ManipalCigna in carrying out your aforesaid NEFT instructions.

Instructions:

- 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.

Date: D D M M Y Y Y Y

Signature of Proposer *:_____
(A policyholder or prospect, who is a person with disability, may duly authorize a representative to give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)

IX. DECLARATION & AUTHORISATION*:

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 authorised 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 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, including seeking and/or sharing of my medical data through ABHA. I/We am/are aware of premium loading for habits and diseases as declared/ mentioned by me/ us above.

☐ I hereby provide my/our explicit and informed consent to Company or its representatives to contact me and members insured under the Policy (including overriding my registration on NCPR/NDNC and/or under any extant TRAI regulations) and / or notify about the services being rendered by the Company.

☐ I/We, hereby agree that the PAN details and other information provided by me/us in the proposal form maybe used by the Company or its authorized representatives to access/download/verify/register/ update my/our KYC documents on/from the CERSAI* CKYC portal for processing this application and for any servicing, claims and other requests. (*Central Registry of Securitisation and Asset Reconstruction and security Interest of India.) I hereby consent that I may receive information from Central KYC Registry through sms / email on the above registered number/email address related to this proposal / policy.

Further, I hereby provide my/our explicit and informed consent to and authorize ManipalCigna Health Insurance Company Limited ("Company") and its representatives to collect, use, share and disclose information including personal information and claim information of all members insured under the Policy ("Personal Information") provided by me, as per the privacy policy of the Company, for the sole purpose of servicing the policy. I also declare that I have the necessary authorization from all members insured under the Policy to collect/ process/ authorize sharing of all Personal Information with the insurance company, insurance intermediaries and associated service providers for sole purpose of insurance policy servicing.

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

Date: D D M M Y Y Y Y **Place:** _____

Signature of Proposer *:_____

(A policyholder or prospect, who is a person with disability, may duly authorize a representative to give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)

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 M M Y Y Y Y **Place:** _____

Signature of Proposer *:_____

(A policyholder or prospect, who is a person with disability, may duly authorize a representative to give declaration on his/her behalf, if required. For further assistance, please visit nearest branch)

XI. ADVISOR / INTERMEDIARY DECLARATION*:

I, _____ (Full Name) 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 **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 out 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 prospectus or tables of the insurers.
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/Others. _____ 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 this policy 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 realized.

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.

Insurance is a subject matter of solicitation.