

**MANIPALCIGNA PROHEALTH SELECT**

**Migration Form**

**PART I**

1. Name of the Policy Holder/ Insured(s):

2. Date of Birth:         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. No. of family members to be included in the policy to be migrated:

Enclosure: Photocopy of the existing policy documents

Date:

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) <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
2.	Has any of the insured been diagnosed or suspected to have any health issue except common cold, flu, fever, loose motions post issuance of previous policy?	(Please indicate Yes / No) <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>

If answer to the Question 1 is 'Yes', please give written consent to the declaration below:

**Declaration**

I am aware that waiting periods, exclusions and other conditions will be applicable in line with the 'Migration' guidelines prescribed by the Insurance Regulatory and Development Authority of India.

Signature of Policy Holder

### PART III

Please fill the following details with respect to claims in health insurance policy(ies) currently held with the Company (Individual or Group)?

Insured	Policy Number	Type of Policy e.g. Medicaid, PA, CI, Hospital Cash	Claim Number	Claimed Amount	Ailment
Insured 1					
Insured 2					
Insured 3					
Insured 4					
Insured 5					

Please Note: Migration and issuance will be subject to complete UW /medical assessment and basis UW guidelines.