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 (East), Mumbai – 400063. IRDAI Registration No. 151. **Call** (Toll Free): 1800-102-4462
Visit: www.manipalcigna.com **E-mail:** customercare@manipalcigna.com

ManipalCigna Health Insurance

FOR OFFICE USE

Branch Name*: _____ Branch Code: _____ BusinessType: Urban /Social / Rural

Intermediary Name: _____ Intermediary Code*: Agent Code / Broker Code / CA Code

Ops Tags Employee DMS Code*: ManipalCigna Employee DMS Code Partner Vertical Name*: Partner Business Vertical Code Partner Branch ID*: Partner Branch Code

Ref B

MANIPALCIGNA PROHEALTH INSURANCE PROPOSAL FORM

(Applicable to Direct Marketing, Online & Affinity Partners)

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.**

For Staff Rebate please provide:
Name of the organization: _____ Name of the Employee: _____
Employee ID: _____
(Applicable only if the Proposer is employee of ManipalCigna or Group Company.)

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 realised.

1. PROPOSER DETAILS:

Title* : Mr. ☐ Mrs. ☐ Ms. ☐ Gender*: Male ☐ Female ☐ Is Employer the Payor: ☐

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

Name* : First* Middle Last*

Correspondence Address*:

Landmark:

City*: Town (District):

State*: Pin Code*:

Permanent Address* :
If same as above, please tick here ☐

Landmark:

City*: Town (District):

State*: Pin Code*:

E-mail : Address 1 Address 2

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

Mobile*:

Occupation* : ☐ Government Employed ☐ Private Service ☐ Self Employed ☐ Housewife ☐ Student ☐ Retired ☐ Others (please specify)

Annual Income : ☐ Up to ₹5 Lacs ☐ ₹5 to 10 Lacs ☐ ₹10 to 15 Lacs ☐ ₹15 to 20 Lacs ☐ Above ₹ 20 Lacs

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

Nationality*: ☐ Indian ☐ NRI ☐ Others (Please specify)

Customer Goods & Service Tax Identification Number (if any)

Pan Card Number*: (Mandatory for premium of ₹50,000 and above accepted in Cash/DD or ₹100,000 and above by Chq/Credit/Debit Card)

Aadhaar Card No:

2. POLICY/PLAN DETAILS:

Plan Type*:	**Tenure*:**	**Proposed Policy Period:**	**Portability:**
Individual ☐ Floater ☐	1 Year ☐ 2 Years ☐ 3 Years ☐	From D D M M Y Y Y Y at ☐☐ : ☐☐ Hrs (Must be on or later than instrument date/ premium payment date)	Yes ☐ No ☐ (If yes portability form to be completed and attached)

	Protect Plan	**Plus Plan**	**Preferred Plan**	**Premier Plan**	**Accumulate Plan**
Sum Insured*:	₹2.5 Lacs ☐ ₹3.5 Lacs ☐ ₹4.5 Lacs ☐ ₹5.5 Lacs ☐ ₹7.5 Lacs ☐ ₹10 Lacs ☐ ₹15 Lacs ☐ ₹20 Lacs ☐ ₹25 Lacs ☐ ₹30 Lacs ☐ ₹50 Lacs ☐	₹4.5 Lacs ☐ ₹5.5 Lacs ☐ ₹7.5 Lacs ☐ ₹10 Lacs ☐ ₹15 Lacs ☐ ₹20 Lacs ☐ ₹25 Lacs ☐ ₹30 Lacs ☐ ₹50 Lacs ☐	₹15 Lacs ☐ ₹30 Lacs ☐ ₹50 Lacs ☐	₹100 Lacs ☐	₹5.5 Lacs ☐ ₹7.5 Lacs ☐ ₹10 Lacs ☐ ₹15 Lacs ☐ ₹20 Lacs ☐ ₹25 Lacs ☐ ₹30 Lacs ☐ ₹50 Lacs ☐
Optional Deductible^^	₹1 Lac ☐ ₹2 Lacs ☐ ₹3 Lacs ☐ ₹4 Lacs ☐ ₹5 Lacs ☐ ₹7.5 Lacs ☐ ₹10 Lacs ☐	₹1 Lac ☐ ₹2 Lacs ☐ ₹3 Lacs ☐ ₹4 Lacs ☐ ₹5 Lacs ☐ ₹7.5 Lacs ☐ ₹10 Lacs ☐	Not available	Not available	₹50000 ☐ ₹1 Lac ☐ ₹2 Lacs ☐ ₹3 Lacs ☐ ₹4 Lacs ☐ ₹5 Lacs ☐ ₹7.5 Lacs ☐ ₹10 Lacs ☐
HMB	₹500	₹2000	₹15000	₹15000	**HMB Option** ₹5000 ☐ ₹10000 ☐ ₹15000 ☐ ₹20000 ☐

HMB - Health Maintenance Benefit

Applicable Discounts:

Long Term Discount ☐ Worksite Discount ☐ Family Discount ☐

Optional Covers (^^Deductible and Voluntary Co-pay cannot be opted under the same plan)

Reduction in Maternity Waiting Period ☐ Voluntary Co-pay^^ ☐ 10% ☐ 20% ☐

Waiver of Mandatory Co-pay ☐ Cumulative Bonus Booster ☐ Hospital Daily Cash Benefit ☐

Zone of Cover (Please tick against your Zone): Zone I ☐ Zone II ☐ Zone III ☐

Zone I: Mumbai, Thane & Navi Mumbai, Gujarat and Delhi & NCR

Zone II: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Kolkata, Pune

Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

a) Persons paying Zone I premium can avail treatment all over India without any Co-pay.

b) Persons paying Zone II premium

i) Can avail treatment in Zone II and Zone III without any Co-pay.

ii) Availing treatment in Zone I will have to bear 10% of each and every claim.

c) Person paying Zone III premium

i) Can avail treatment in Zone III, without any Co-pay.

ii) Availing treatment in Zone II will have to bear 10% of each and every claim.

iii) Availing treatment in Zone I will have to bear 20% of each and every claim.

Your default zone is based on the city mentioned in your correspondence address. You have an option of upgrading to a higher zone which will enable you to get wider hospital network access outside your zone. If you choose to upgrade your Zone, please tick against the Zone of Cover you would like to opt.

Note: Zone can only be upgraded to higher than default. For complete details on classification of zone and applicable conditions please refer to the product brochure.

Nominee Name#: First* Middle Last*

Relationship with Proposer:

In the event of death of the Proposer, any payment due under the Policy shall become payable to the nominee 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 nominee.

3. E-INSURANCE ACCOUNT (EIA) DETAILS:

Do you want policy document in dematerialised format?^ **Yes** ☐ **No** ☐

^If you open an eIA account, all communication including policy document shall be made available in electronic format

Do you have existing eIA account number? **Yes** ☐ **No** ☐

If yes then please provide eIA account number:

If you do not have eIA account number then please provide mentioned details in eIA Annexure.

A) Select the preferred Insurance Repository in which e-Insurance Account (e-IA) needs to be opened:

1) Karvy Insurance Repository Limited ☐ 2) CAMS Repository Services Limited ☐

4. INSURED DETAILS*:

Is the Address of insured different from that of the Proposer? **Yes** ☐ **No** ☐

If Yes please provide:

Sr No.	Name (First*, Middle, Last*)	Gender M/F*	DOB* (DD/MM/YYYY)	Relationship with Proposer*	Ht* (Cms)	Wt* (Kgs)	Occupation / Industry Type / Nature of Job*	City*	Sum Insured* (only for Individual cover)
1									
2									
3									
4									
5									

5. MEDICAL AND LIFESTYLE INFORMATION*:

Please answer the below mentioned questions in Yes (Y) / No (N). If the answer to any of the questions is Yes, please 3 against the relevant insured Persons.

		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Have you or any of the persons proposed for insurance, ever suffered from or taken treatment, or hospitalised for or have been recommended to take investigations / medication / surgery or undergone a surgery for the following medical conditions? Yes ☐ No ☐	☐	☐	☐	☐	☐
2	Any illness/disease/injury/disability suffered from in the past 48 months other than for childbirth, flu or for minor injuries that have completely healed. Yes ☐ No ☐	☐	☐	☐	☐	☐
3	Are you currently in good health and not undergoing any treatment or medication for any illness/medical condition (Physical, Psychiatric, Mental illness /disorders, Sleep disorders). Yes ☐ No ☐	☐	☐	☐	☐	☐

6. ADDITIONAL MEDICAL INFORMATION:

If answer to any of the above questions is Yes, please provide further details of the medical condition in a separate sheet. If you wish to provide additional details about your Attending Physician or details of other Insurance Policies held by you, please attach additional sheets.

Signature of Proposer*:

7. PAYMENT DETAILS*:

Premium paid by: FIRST* MIDDLE LAST* Relationship to proposer

Premium Amount ₹: in Words:

Payment Option: Cheque ☐ Demand Draft ☐ Pay Order ☐ Credit Card ☐ Debit Card ☐ Cash^ ☐

(^For cash payment of ₹ 50,000 and above PAN no. is mandatory)

For Cheque / DD / Debit Card / Credit Card / PO / Others (Please specify)

(Payable in favour of "ManipalCigna Health Insurance Compay Limited" - Proposal Form No.:

Instrument/Transaction Number: Instrument/Transaction Date:

Instrument /Transaction Amount:

Bank Name:

Payment to be collected only from Proposers Card/Bank Account

Signature:

8. 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.

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 NEFTmandate 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 NEFTonly. (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***

9. 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 authorized 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.

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

10. 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:**

11. INTERMEDIARY DECLARATION*:

I, (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized 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 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 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**

Insurance Advisor / Specified Person of the Corporate Agent / Authorised employee of the Broker / Relationship Officer

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 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 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 prospectus or tables of the insurers.

2) Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to 10 lakh rupees.

Suggested Format for Additional Medical Information:

If answer to any of the questions asked in Section 5 (Medical and Lifestyle Information) is Yes, please provide further details of the medical condition.

Sr No.	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Name of Insured					
Name of illness / injury suffering from or suffered in the past					
Date of first diagnosis (Month & Year)					
Name of Medication/Treatment					
Whether fully cured					

Date: D D M M Y Y Y Y **Signature of Proposer*:**

ManipalCigna ProHealth Insurance | UIN: CTTHLIP18045V031819 | URN: 2017/PHLTA/V2.01 | April 2019 onwards

ACKNOWLEDGEMENT: (Tear Off)

Received from Ms. / Mrs. / Mr:

a sum of ₹ through Cash# / Cheque / DD / Credit Card / Debit Card No. against your proposal for ManipalCigna ProHealth Insurance policy.

Signature of ManipalCigna Official / Intermediary: Date: D D M M Y Y Y Y

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 ManipalCigna ProHealth Insurance 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

ManipalCigna Health Insurance

NATIONAL AUTOMATED CLEARING HOUSE (NACH) MANDATE FORM

NACH option is a mandate to automatically pay your RENEWAL PREMIUMS ONLY by debiting the bank account specified by you, on / around the due date.

- PLEASE FILL THE FORM IN BLOCK LETTERS
- PLEASE FILL THE FORM WITH UTMOST CARE
- NO OVERWRITING/WHITENER USAGE ALLOWED
- PLEASE STRIKE OUT PARTS, WHICH ARE NOT APPLICABLE AND WRITE 'N.A.' STROKES OF THE PEN, DOTS AND DASHES WILL NOT BE ACCEPTED AS REPLIES.

Important Note:

- Please read the terms & condition before completing this form.
- Please ensure that this mandate form reaches the company at least 30 days prior to the next premium due date.
- Incase of applying for multiple policies, please fill separate mandate for each policy.
- In case of any modification/ revision in the policy terms or premium, if You do not agree with the revision, You may choose to opt out of the NACH facility, informing the insurer at least fifteen days prior to the premium due date.

Authorization of customer to pay insurance premium of ManipalCigna Health insurance Company Limited, through NACH facility.

PARTICULARS OF THE POLICY HOLDER

Name of the Policyholder :

Policy / Proposal Number :

BANK ACCOUNT HOLDER'S RELATIONSHIP WITH POLICYHOLDER Please tick (✓)

☐ Self ☐ Spouse ☐ Parent/ Grand Parent/Child ☐ Employer/Employee

☐ HUF ☐ Sole Proprietorship Concern of Self/Spouse ☐ Proprietorship Concern of Parent/Grandparent/Children

Note:

• If the Account holder is different from the current payor in the Policy, the KYC and AML documents shall be submitted (if required)

• If joint account is NOT an either or survivor account, both account holders' signatures are mandatory

Please tick (✓)

☐ I have enclosed Cancelled Cheque with Preprinted Account Holder Name & Bank Account Number.

☐ I have enclosed Bank Account Statement/ Pass Book Copy along with Cancelled Cheque (only if Account Details are not Preprinted on the Cancelled Cheque)

I authorize ManipalCigna Health Insurance Company Ltd. (ManipalCigna) to debit my bank account towards payment of applicable premium for renewal of the policy. I understand and agree that the premium amount to be debited may vary due to loading charges on underwriting, if any, and changes in statutory taxes applicable from time to time.

ManipalCigna Health Insurance

UMRN * D D M M Y Y Y Y

Sponsor Bank Code HDFC0000060 Utility Code NACH00000000019491

Tick (✓)

CREATE ✓
MODIFY
CANCEL

I/We hereby authorize ManipalCigna Health Insurance Co. Ltd. *to debit (tick ✓) SB / CA / CC / SB-NRE / SB-NRO / Other

*Bank a/c number

*With Bank Name Bank *IFSC or MICR

*an amount of Rupees ₹

FREQUENCY ~~Mthly~~ ~~Qtly~~ ~~H-Yrly~~ ~~Yrly~~ ✓ As & when presented DEBIT TYPE ~~Fixed Amount~~ ✓ Maximum Amount

*Reference 1 Policy Number *Phone No.

Reference 2 ~~Not Applicable~~ *Email ID

I agree for the debit of mandate processing charges by the bank whom I am authorizing to debit my account as per latest schedule of charges of the bank

PERIOD

*From D D M M Y Y Y Y

To ~~N A~~

Or ✓ Until Cancelled

*Signature of Primary Account holder Signature of Account holder Signature of Account holder

*1. Name as in bank records 2. Name as in bank records 3. Name as in bank records

This is to confirm that the declaration has been carefully read, understood & made by me/us. I am authorizing the user entity/corporate to debit my account, based on instructions as agreed and signed by me. I have understood that. I am authorized to cancel/amend this mandate by appropriately communicating the cancellation / amendment request to the user entity/corporate or the bank when I have authorized the debt.

DECLARATION FOR NACH

1. I hereby declare that the above information is correct and complete.
2. I acknowledge that I have read, understood and agree to be bound by the "Terms and Conditions" detailed in this form, as are currently in effect and as may be amended by ManipalCigna from time to time.
3. I wish to avail of the NACH facility and hereby express my unconditional consent to debit my above mentioned account through NACH for premiums of ManipalCigna Health Policy (including rider, if opted).
4. I understand and accept that the transaction will be effected into the policy on not exceeding two working days prior to the due date. If the transaction is delayed or not effected at all for reasons of incomplete or incorrect information, I shall not hold ManipalCigna responsible. Any charges/ penalty levied towards this facility shall not be payable by ManipalCigna. In case of failure of transaction or non-receipt of the renewal premium, the policy will not be renewed and it will terminate by the end of the grace period.
5. I authorize the above mentioned bank to debit my bank account if my NACH mandate is active and until I give a written request for cancellation of NACH.
6. I hereby authorize ManipalCigna, to enable the NACH facility for my premium payments and in the instance of NACH debit dishonor, to re-debit my account with the mentioned bank to recover the premium payable.
7. I understand and agree that the submission of this form does not mean that the request will be processed.
8. I understand that I will keep the policy in force to avail any benefit from ManipalCigna.
9. I understand that any payout under the policy by ManipalCigna shall be strictly in accordance with the policy terms and conditions. Also any payment shall be subject to realisation of the last renewal premium payment by ManipalCigna and subject to policy being inforce.
10. I also understand and agree that the Company reserves the right to use any alternative payment option.
11. I understand that I have an option to discontinue the premium payment through NACH facility by informing the insurer at least fifteen days prior to the premium due date.
12. If the policy is discontinued or terminated, NACH facility will be deactivated for the policy and no further premium would be debited from customer's registered account.

Application Date D D M M Y Y Y Y

Maximum Amount: ₹ _____

Accountholder's Signature	2nd Signature (in case of Joint account holder)	Policyholder's Signature (if Accountholder differs from policyholder)

IN CASE SIGNATURE OF THE POLICYHOLDER IS IN VERNACULAR.

Note: The below must be witnessed by someone other than advisor/ employee of the company. The signature of the Policyholder should be attested by a person of standing whose identity can easily be established and this declaration should be made by him/her.

I _____ (name) holding _____ (Identity Card type) _____ (Identity Card no.) hereby declare that I have explained the contents of the Debit form to the Policyholder in _____ language and that I have read out to the Policyholder the information dictated by the Policyholder. The information filled in the Debit form is the exact replication of the information provided to me by the Policyholder and that the Policyholder has affixed his/her signature on the Debit form after fully understanding the contents thereof.

Witness Details:

Name:

ID Proof Type: ID Proof Number:

Signature of the Person making the Declaration

Instructions to fill mandate:

1. UMRN- To be left blank
2. Date in DD/MM/YYYY format
3. Sponsor Bank IFSC Code – <<XXXXXXXXXX>> already printed
4. Utility Code – Unique Code of the entity to whom the mandate is being given- Already printed
5. Name of the entity to whom the mandate is being given – Already printed
6. Account type – SB/ CA/ CC/ SB- NRE/ SB- NRO/ OTHER
7. Tick- Select your appropriate action
   a. Create – For New Mandate
   b. Modify – For Changes/ Amendment on existing mandate
   c. Cancel – For Cancelling the existing registered mandate
8. Customer's bank account number for debiting the account
9. Name of Bank
10. Customer bank's IFSC code or MICR code
11. Amount in Words
12. Amount in figures
13. Frequency at which the debit should happen
14. Whether the amount is fixed or variable
15. Reference 1 – Policy no of the customer
16. Reference 2 – Any reference as requested by ManipalCigna Health Insurance Company Ltd
17. Customer's phone number with STD code
18. Customer's email id
19. Period for which debit mandate is valid. Kindly enter 'Start date'.
20. Signature of the accountholder
21. Name of the account holder

This is not a part of Proposal Form