CignaTTK Health Insurance Company Limited
Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063. IRDA Registration No. 151. **Call** (Toll Free): 1-800-10-24462
Visit: www.cignattkinsurance.in **E-mail:** customercare@cignattk.in

Cigna TTK Health Insurance

Proposal Form No.: _____

FOR OFFICE USE

Branch Name*: Branch Code: Business Type: Urban/ Social/ Rural
Intermediary Name: Intermediary Code*: Agent Code / Broker Code / CA Code
Ops Tags Employee DMS Code*: CignaTTK Employee DMS Code Partner Vertical Name*: Partner Business Vertical Code Partner Branch ID*: Partner Branch Code

Ref A:
Ref B:

CIGNATTK PROHEALTH INSURANCE PROPOSAL FORM

Ref C:

(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.

The issuance of this form by CignaTTK 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.

1. PROPOSER DETAILS:

Title* : Mr. Mrs. Ms. Gender*: Male Female Is Employer /Group Administrator Proposer:

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

Annual Income : Up to 5Lacs 5 - 10Lacs 10 - 15Lacs 15 - 20Lacs Above 20Lacs

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

Nationality*: Indian NRI Others (Please specify)

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)

2. POLICY/PLAN DETAILS:

Plan Type* :	**Tenure*:**	**Proposed Policy Period:**	**Portability:**
Individual Floater	1 Year 2 Year 3 Year	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)
Sum Insured*: **Protect Plan** ₹2.5 Lacs ₹3.5 Lacs ₹4.5 Lacs ₹5.5 Lacs ₹7.5Lacs ₹10 Lacs	**Optional Deductible Protect Plan** ₹1 Lac ₹2 Lacs ₹3 Lacs	**Applicable Discounts:** Long Term Discount Direct Discount Worksite Discount Family Discount	
Plus Plan ₹4.5 Lacs ₹5.5 Lacs ₹7.5 Lacs ₹10 Lacs	**Plus Plan** ₹1 Lac ₹2 Lacs ₹3 Lacs	**Optional Covers#** Reduction in Maternity Waiting Period Voluntary Co-pay 10% 20% Waiver of Mandatory Co-pay Cumulative Bonus Booster	
Preferred Plan ₹15 Lacs ₹30 Lacs ₹50 Lacs	**Not Available**	**Zone of Cover (Please tick against your Zone):** Zone I (All India Cover) Zone II (All India Cover excluding cities in Zone I) Zone III (Rest of India excluding cities in Zone I & II)	
Premier Plan ₹100 Lacs	**Not Available**	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.	

#Deductible and Voluntary Co-pay cannot be opted under the same plan

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Accumulate Plan	Optional Deductible (Accumulate Plan)	HMB Option
₹5.5 Lacs	₹50,000	₹5000
₹7.5 Lacs	₹1Lac	₹10000
₹10 Lacs	₹2Lacs	₹15000
₹15 Lacs	₹3Lacs	₹20000
₹20 Lacs	₹4Lacs	
₹25 Lacs	₹5Lacs	

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.

3. INSURED DETAILS:

Sr No.	Name (First*, Middle, Last*)	Gender*	DOB* (DD/MM/YYYY)	Relationship with Proposer*	Height* (Cms)	Weight* (Kgs)	Occupation* Nature of Job	City	Sum Insured (only for individual cover)
1									
2									
3									
4									
5									

4. 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 ✓ against the relevant Insured Person

		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 a medical condition? **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 or mental). **YES** **NO**					

5. ADDITIONAL MEDICAL INFORMATION:

If answers 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*:

6. PAYMENT DETAILS*:

Premium paid by:

Relationship to proposer:

Premium Amount: in Words:

Payment Option: Cheque Demand Draft Pay Order Credit Card Debit Card Cashˆ

(PAN Card copy is Mandatory for premium of ₹50,000 and above accepted in Cash/DD or ₹100,000 and above by Chq/Credit/Debit Card)

a. For Cheque / DD / PO (Payable in favour of "CignaTTK Health Insurance Company Limited" - Proposal Form No.: _____)

Name of the Premium Payer:

Instrument Number: Instrument Date: Instrument Amount:

Bank Name:

b. For Credit / Debit Card:

Card No.: 16 digit Expiry Date: D D M M Y Y Y Y Card Type: Visa / Master / Amex:

Name on the Card: *Payment to be collected only from Proposers Card / Bank Account

Signature:

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7. 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 CignaTTK 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: Cigna TTK 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. Cigna TTK shall be indemnified against any loss/damage/claims caused to Cigna TTK 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*

8. 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.

☐ I hereby confirm the receipt of Premium acknowledgment slip which is attached with this proposal form.

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

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 answers to any of the questions asked in Section 4 (Medical and Lifestyle Information) is Yes, please provide further details of the medical condition.

	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)					
Treatment/medication received/receiving					
Whether fully cured					

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

Name of SP*: **Signature of SP*:**

Date: D D M M Y Y Y Y

ACKNOWLEDGEMENT: (Tear Off)

Received from Ms. / Mrs. / Mr:

a sum of Rs. through Cash# / Cheque / DD / Credit Card / Debit Card No. against Your proposal for CignaTTK ProHealth Insurance.

Signature of Cigna TTK Official / Intermediary: Date: D D M M Y Y Y Y

Cigna TTK Official / Intermediary Name:

Time: Place:

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 CignaTTK 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 CignaTTK ProHealth Insurance and the Company shall have no liability to make any payment if premium is not received by CignaTTK 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 CignaTTK branch or its authorized 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, CignaTTK Health Insurance Company Limited will inform you and refund any payment received from you without interest.

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