



STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

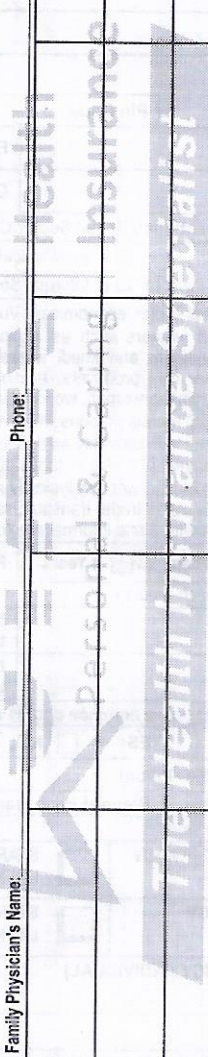
Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam,

Chennai - 600 034. ★ Phone : 044 - 28288800 ★ Email : support@starhealth.in

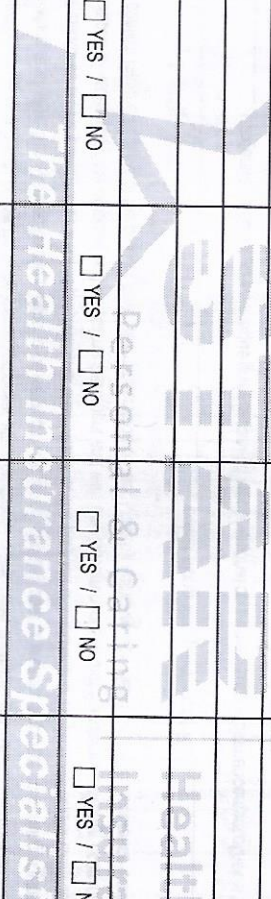
Website : www.starhealth.in ★ CIN : U66010TN2005PLC056649 ★ IRDAI Regn. No. : 129

COMMON PROPOSAL FORM Unique Reference No.: SHAI/PR0002		Ref. No.			The company will not be on risk until the proposal has been accepted and full payment of premium has been received. Please fill up the form in block letters.	
Policy Issuing Office:		Policy No.			SM CODE	SM NAME
		AGENT / CORPORATE AGENT / BROKER / IMF / CODE	BA0000172379		AGENT / CORPORATE AGENT / BROKER / IMF / NAME	Dhananjay Kumar
Name of the Proposer Mr / Mrs / Ms.					Date of Birth :	
Occupation of the Proposer					Annual Income Rs.:	
Residential Address:			Office Address:			
Pin Code:			Pin Code:			
Mobile Number			Email ID			
PAN Number			GST Number			
BUSINESS TYPE	Do you come under below mentioned Social Sector Classification*: <input type="checkbox"/> Yes <input type="checkbox"/> No				Rural and Social Sector Classification	
	If Yes : <input type="checkbox"/> a. Unorganized Sector <input type="checkbox"/> b. Economically Vulnerable or Backward Classes <input type="checkbox"/> c. Other Categories of Persons <input type="checkbox"/> d. Informal Sector				Are you a ASHA workers	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Are you a MGNREGA workers	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>* "Social Sector" includes unorganised sector, informal sector, economically Vulnerable or backward classes and other categories of persons, both in rural and urban areas;</p> <p>a. "Unorganised sector" includes self-employed workers such as agricultural labourers, bidi workers, brick kiln workers, carpenters, cobblers, construction workers, fishermen, hamals, handicraft artisans, handloom and khadi workers, lady tailors, leather and tannery workers, papad makers, powerloom workers, physically handicapped self-employed persons, primary milk producers, rickshaw pullers, safaikarmacharis, salt growers, sericulture workers, sugarcane cutters, tendu leaf collectors, toddy tappers, vegetable vendors, washerwomen, working women in hills, daily wagers, hired drivers and coolies or such other categories of persons.</p> <p>b. "Economically Vulnerable or Backward Classes" means persons who live below the poverty line.</p> <p>c. "Other Categories of Persons" includes persons with disability as defined in the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 and who may not be gainfully employed; and also includes guardians who need insurance to protect spastic persons or persons with disability.</p> <p>d. "Informal Sector" includes small scale, self-employed workers typically at a low level of organisation and technology, with the primary objective of generating employment and income, with heterogeneous activities like retail trade, transport, repair and maintenance, construction, personal and domestic services and manufacturing, with the work mostly labour intensive, having often unwritten and informal employer-employee relationship.</p>						
Policy Term (Please ✓)	<input type="checkbox"/> 1 Year / <input type="checkbox"/> 2 Years / <input type="checkbox"/> 3 Years	Period of Insurance	From	To		
Pls check the brochure for policy term in respect of each product						
NOMINATION	Nominee's Name	Relationship to Proposer	Date of Birth	Age	Yrs	
	Name of the Appointee (if nominee is a minor)	Relationship to Nominee	Date of Birth	Age	Yrs	
(Incase of Multiple nominees a separate form containing nominee details should be enclosed duly specifying the % to each nominee)						
Do you want to pay the premium in Instalments: <input type="checkbox"/> YES <input type="checkbox"/> NO						
If yes choose Instalment options (Please Select the Option) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Halfyearly						
Premium can also be paid: Annually for 1 year term / Biennial for 2 year term / Triennial for 3 years						
Please check brochure for Instalment facility in each product						
Please Tick (✓) the Policy Opted	<input type="checkbox"/> STAR HEALTH GAIN INSURANCE POLICY UIN No.: SHAHLIP21262V032021	<input type="checkbox"/> STAR CRITICARE PLUS INSURANCE POLICY UIN No.: SHAHLIP21179V022021	<input type="checkbox"/> STAR FAMILY DELITE INSURANCE POLICY UIN No.: SHAHLIP21178V022021			
	<input type="checkbox"/> YOUNG STAR INSURANCE POLICY UIN No.: SHAHLIP21217V032021	<input type="checkbox"/> STAR COMPREHENSIVE INSURANCE POLICY UIN No.: SHAHLIP21263V062021	<input type="checkbox"/> FAMILY HEALTH OPTIMA INSURANCE PLAN UIN No.: SHAHLIP21011V052122			
	<input type="checkbox"/> MEDICLASSIC INSURANCE POLICY (INDIVIDUAL) UIN No.: SHAHLIP21215V052021	<input type="checkbox"/> SENIOR CITIZENS RED CARPET HEALTH INSURANCE POLICY UIN No.: SHAHLIP21265V042021				
	Sum Insured on Floater Basis Rs. in Lakhs* : _____					
Applicable for Young Star Insurance Policy Plan Opted (Please ✓) <input type="checkbox"/> Silver <input type="checkbox"/> Gold						
*please check brochure for the available sum insured option in respect of each product.						
Family Size (A=Adult, C=Child) (✓)	<input type="checkbox"/> 1A <input type="checkbox"/> 1A+1C <input type="checkbox"/> 1A+2C <input type="checkbox"/> 1A+3C	<input type="checkbox"/> 2A <input type="checkbox"/> 2A+1C <input type="checkbox"/> 2A+2C <input type="checkbox"/> 2A+3C		Applicable for Family Health Optima Insurance Plan		
				Numbers of Parents / Parent-in-law (as part of the same floater sum insured)		
I would like to receive my insurance policy and all the information related to the proposed insurance policy through insurance repository				<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you wish to receive the physical copy of the policy document <input type="checkbox"/> YES <input type="checkbox"/> NO	
If you already have an e-Insurance Account (eIA) number, kindly provide e-Insurance Account (eIA) number: _____						
If you don't have an (eIA) number, choose any one Insurance Repository <input type="checkbox"/> KARVY <input type="checkbox"/> CAMSRep - CAMS Insurance Repository & Services <input type="checkbox"/> CIRL - Central Insurance Repository Limited <input type="checkbox"/> NDML - NSDL Data Management Services limited						
Bank Details of the Proposer	Account Number			Type of Account : <input type="checkbox"/> SB <input type="checkbox"/> CA <input type="checkbox"/> Others please specify		
	Name of the Bank			Name of the Branch	IFSC Code	
Please attach a photo copy of cancelled cheque leaf of the above Bank Account.						
Payments Details	Annual Premium	Rs.	Mode of Payment : Cash / Chque / DD / Credit Card / Debit Card / NEFT / CC Mandate / ECS			
Cheque / DD No.	Date		Drawn on	Branch		
Please attach any one proof of Date of Birth : <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Voter ID <input type="checkbox"/> PAN Card <input type="checkbox"/> Driving License <input type="checkbox"/> Aadhar Card <input type="checkbox"/> Any other Govt. Recognised Proof						

Details of the person proposed for insurance		Insured Person - 1		Insured Person - 2		Insured Person - 3		Insured Person - 4		Insured Person - 5		Insured Person - 6	
Name		M / F / Thirdgender	DDMMYYYY	M / F / Thirdgender	DDMMYYYY	M / F / Thirdgender	DDMMYYYY	M / F / Thirdgender	DDMMYYYY	M / F / Thirdgender	DDMMYYYY	M / F / Thirdgender	DDMMYYYY
Gender	Date of Birth	CMS	KGS	CMS	KGS	CMS	KGS	CMS	KGS	CMS	KGS	CMS	KGS
Height (cms)	Weight (kgs)												
Relationship with proposer													
Occupation	Annual Income (Rs.)												
Do you want Gold Plan [Applicable for Mediclaim Insurance Policy (Individual)]		<input type="checkbox"/> YES / <input type="checkbox"/> NO		<input type="checkbox"/> YES / <input type="checkbox"/> NO		<input type="checkbox"/> YES / <input type="checkbox"/> NO		<input type="checkbox"/> YES / <input type="checkbox"/> NO		<input type="checkbox"/> YES / <input type="checkbox"/> NO		<input type="checkbox"/> YES / <input type="checkbox"/> NO	
Applicable for Young Star Insurance Policy Plan Opted		<input type="checkbox"/> Silver / <input type="checkbox"/> Gold		<input type="checkbox"/> Silver / <input type="checkbox"/> Gold		<input type="checkbox"/> Silver / <input type="checkbox"/> Gold		<input type="checkbox"/> Silver / <input type="checkbox"/> Gold		<input type="checkbox"/> Silver / <input type="checkbox"/> Gold		<input type="checkbox"/> Silver / <input type="checkbox"/> Gold	
Sum Insured Opted (For individual Policy) (Rs.)													
Add-ons : [Applicable for Mediclaim Insurance Policy (Individual)] - Do you want add on covers - If Yes, Please tick (✓) (Patient Care add-on is available only for Insured Persons above 60yrs of age.)		<input type="checkbox"/> Hospital Cash		<input type="checkbox"/> Hospital Cash		<input type="checkbox"/> Hospital Cash		<input type="checkbox"/> Hospital Cash		<input type="checkbox"/> Hospital Cash		<input type="checkbox"/> Hospital Cash	
		<input type="checkbox"/> Patient Care		<input type="checkbox"/> Patient Care		<input type="checkbox"/> Patient Care		<input type="checkbox"/> Patient Care		<input type="checkbox"/> Patient Care		<input type="checkbox"/> Patient Care	
Existing Insurance Coverage with this company and any other company - give details													
1. Name of the Insurance Company													
2. Period of Insurance													
3. Sum Insured (Rs)													
4. Policy No.													
Details of Claims		1. Allment for which Claim was made		Year		Year		Year		Year		Year	
2. Claim Amount Paid / Rejected													
Health History: Please provide answer in detail. A mere dash is not sufficient.													
1. Is the person proposed for insurance in good health free from physical and mental disease or infirmity. If not give details													
2. Has the person proposed for insurance consulted/ diagnosed /taken treatment /been admitted for any illness/injury. If Yes, give details													
3. Does the person proposed for insurance have any complications during / following birth. If yes, please submit all necessary documents.													
4. Has the person proposed for insurance ever suffered or suffering from any of the following													
a) Diabetes Mellitus - If Yes, since when													
b) High BP, Cholesterol - If Yes, since when													
c) Heart Disease - If Yes, since when													
d) Stroke, epilepsy, fainting attack, chronic headache, Parkinson's disease, Alzheimer's disease, - If Yes since when													
e) Tuberculosis, asthma, other respiratory infections - If Yes, since when													
f) Disease of bones/joints, slipped disc, spinal disorder, injury to ligaments - If Yes, since when													
g) Cancer, Pre Cancerous Lesion - If Yes, since when													
h) Gynecological disorder such as DUB, Fibroid Uterus, Ovarian cyst - or have undergone cesarean / Hysterectomy If Yes, since when													
i) Treatment for sub fertility or has been advised													



Diseases - If Yes, since when k) Disease of Prostate / Fistula / Piles / Genital diseases - If Yes, since when l) Cataract and other diseases of the eye and ENT disease - If Yes since when m) Any Other Problem (Please Specify)						
5. Has the person's proposed for insurance						
a) Undergone any medical test?						
b) Prescribed any medicines? If yes i) Name the illness for which medicines have been prescribed ii) Details of medicines and drugs prescribed iii) Period for which these drugs were taken.						
c) Been advised for any surgery / treatment ? - If Yes, give details						
d) Received / receiving any payment for any disability / injury / illness / disease. Give details						
6. Does the person proposed for insurance a) Chew Tobacco - If Yes, since when b) Smoke - If Yes, since when c) Consume Alcohol - If Yes, since when						
7. Is the person proposed for insurance positive for HIV if yes, please mention your CD4count (Please attach proof)						
8. Buy back PED (Optional Cover) required?	<input type="checkbox"/> YES / <input type="checkbox"/> NO	<input type="checkbox"/> YES / <input type="checkbox"/> NO	<input type="checkbox"/> YES / <input type="checkbox"/> NO	<input type="checkbox"/> YES / <input type="checkbox"/> NO	<input type="checkbox"/> YES / <input type="checkbox"/> NO	<input type="checkbox"/> YES / <input type="checkbox"/> NO
9. Does the Insured Occupation require to engage in manual labour?						
10. Does the Insured Person engage in or propose to engage in any activity or sport which is hazardous or adventurous in nature such as Racing, Mountaineering, Winter sport etc if so please specify	Mr / Ms					
11. Name of the family member chosen for Personal Accident Insurance under Section-10 (Note: The sum insured for personal accidental cover (Accidental death & Permanent total disability) is by default equal to the sum insured opted for health cover. For person above 70years and dependent children the maximum sum insured is Rs.10,00,000/-)						
Declaration of the Agent/ Intermediary: // We confirm that the product's suitability has been explained to the proposer. The Information furnished in the proposal is true to the best of my knowledge and recommend acceptance of the proposal. (Please Enclose Insurance Agent's Confidential Report, If Any)						
Code	BA07DD172379	Name of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF /	Dhananjay Kumar		Signature of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF	



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STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED
Acknowledgement

Received the proposal for _____ policy from Mr/ Mrs/ Ms. _____ along with payment of Rs. _____/- by Cash / vide Cheque/ DD No. _____ dt. _____ drawn on _____ The Cash/Cheque given by you is banked for operational convenience and banking of the Cash/Cheque does not mean acceptance of risk by us. The receipt of the Cash/Cheque will also be acknowledged by our office vide collection receipt. If the proposal is accepted, the cover will commence from the date of the collection receipt, subject to realization of the Cheque. If the proposal is not accepted, the amount paid will be refunded. Contact our office, in case policy is not received within 15 days from the date of payment of premium.

Name & Code of the authorised person: _____
Signature of the authorised person: _____

Date: _____ **Place:** _____

Please affix stamp size photograph of Insured Person - 1	Please affix stamp size photograph of Insured Person - 2	Please affix stamp size photograph of Insured Person - 3	Please affix stamp size photograph of Insured Person - 4	Please affix stamp size photograph of Insured Person - 5	Please affix stamp size photograph of Insured Person - 6
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Declaration

1. I 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 am authorized to propose on behalf of these other persons. 2. 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 insurer and that the policy will come into force only after full payment of the premium chargeable. 3. I further declare that I 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. 4. I declare that I consent to the company seeking medical information from any doctor or from a hospital who/which at anytime has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement. 5. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and /or claims settlement and with any Governmental and/or Regulatory authority. I confirm that the payment is made through my card / bank account. I also confirm that the source of funds for premium paid under this policy is legal. I hereby confirm that the features of the product have been understood by me. I hereby authorize Star Health and Allied Insurance Company to contact me. It will override my registry on the NCPR.

Submitted the above proposal for _____ policy along with payment of Rs. _____ by cash/wide cheque/DD no. _____ dated _____ I understand that the cash/cheque given is banked for operational convenience and commencement of risk is subject to the acceptance of proposal by you.

Place	Date	Name	Signature / Thumb impression of the proposer:
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WHERE THE PROPOSER IS ILLITERATE OR SIGNS IN A LANGUAGE DIFFERENT FROM THAT OF THE LANGUAGE OF THE PROPOSAL FORM.

I hereby confirm that the details have been explained to the proposer.

Date	Name of the person who explained	Signature of the person who explained
		Signature / Thumb impression of the proposer

- Prohibition of Rebates: Section 41 of Insurance Act 1938.**
- 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 prospectuses or tables of the insurer.
 - 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.