Form No. M C I 0 6

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Corporate Office : 1, New Tank Street, Valluvarkottam High Road, Chennai - 600 034.

MEDI-CLASSIC PROPOSAL FORM

PROPOSAL. NO. :	MC/

Issuing Office :

Premium Payment Details : ☐ Cash ☐ Cheque ☐ DD Cheque/DD No. Date

Coverage Required : From To Dep. Pre. Rt. No. Date

Bank Name/Branch

Mktg. Officer Name Code No

Agents Name : Code No

Corporate Agent's Name Code No

The Company will not be on risk until the Proposal has been accepted and full payment of the premium made. Males above 45 years and females above 40 years and the Persons whom the company may require, have to undergo Medical Examination to be arranged by the company before acceptance of this proposal. The liability of Star Health and Allied Insurance Company commences only upon the acceptance of this proposal notwithstanding the payment of any deposit. Please fill up the form in BLOCK letters. Please submit stamp size photographs of each of the persons proposed for insurance for issuance of Identity Cards. If you are in any doubt about the information to be given, please seek the advice and guidance from your insurance advisor or agent.

Business Type ☐ Urban Rural Sector : _____

1. PROPOSER DETAILS ☐ Mr. ☐ Mrs. ☐ Ms.

First Name Middle Name Last Name

Name of Proposer

Permanent Address

City/Taluk District State Pin Code

Address for Communication

City/Taluk District State Pin Code

STD Code Phone No. Fax Cell

E-mail IT Pan No.

Marital Status of Proposer ☐ Single ☐ Married

Educational Qualification Occupation

Existing SHAICL Customer Y N If yes, Customer Code No :

2. DETAILS OF PERSON(S) TO BE COVERED INCLUDING PROPOSER

	1	2	3	4
Name of the Person to be Insured				
Relationship with the Proposer				
Date of Birth	D D M M Y Y Age	D D M M Y Y Age	D D M M Y Y Age	D D M M Y Y Age
SUM INSURED				
Educational Qualification*	NM M G PG PC	NM M G PG PC	NM M G PG PC	NM M G PG PC

(NM - Non-Matric, M-Matric, G-Graduate, PG - Post Graduate, PC - Professional Course)

	1	2	3	4
Occupation**				

** *Occupation : Service - State Govt. - **SG**, Central Govt. - **CG**, Public Sector - **PS**, Private Sector - **PR**, Business - **B**, Profession - **P**, Self Employed - **F**, Student - S, Agriculturist -**A**, House wife - **H,** Pensioner - **PE, Others - O.***

Average Monthly Income

3. Previous Insurance Details

Are you covered under any other Medical Insurance policies or any other such scheme ?	Y	N	Y	N	Y	N	Y	N
If yes, details of : Name of the Insurance Company								
Period of Insurance								
Sum Insured								

ATTACH STAMP SIZE PHOTOS FOR ISSUE OF ID CARDS

Stamp Size Photo-1 | Stamp Size Photo-1 | Stamp Size Photo-1 | Stamp Size Photo-1

Family Details - of the Proposer

Family Member	Age	Health status if alive	Age when died If not alive	Cause of death
Father				
Mother				
Brothers				
Sisters				
Spouse				
Children				

4. PLAN DETAILS

Please select the Plan Opted : ☐ Medi-Classic ☐ Medi-Family Package (applicable only for persons below 40 years)

Add-on Cover : ☐ Hospital Cash (for Medi-Classic) ☐ Patient Care (for persons above 65 years) ☐ Inclusion of New-born from birth (family package)

Do your wish to opt for Co-pay : Y N

5. MEDICAL HISTORY

Please provide the following information? (Yes/No)	Insured 1	Insured 2	Insured 3	Insured 4
Are you in good health and free from physical and mental disease or infirmity or medical complaints? If not, give full details.				
Any proposal for Medical insurance refused, cancelled or higher premium charged by any Insurance company? If your answer is YES, please attach separate sheet				
Has any claim been rejeted by the previous Insurer, If Yes, please provide details.				
Medical History and other details of the insured persons (These details are not only required to underwrite the proposal form but also to render Medical advice as may deem fit) (Please answer Yes or No. A mere dash is not sufficient) Have you ever suffered from any of the diseases/illness ? If yes, give details.				
a. Diabetes Mellitus				
b. High Blood Pressure, Heart Diseases including Ischaemic Heart Disease (IHD)/ Rheumatic Heart Disease.				
c. Stroke, epilepsy, fainting attack, chronic headache				
d. Tuberculosis, Asthma, respiratory allergic disorders,				
e. Any disease of bones/joints.				
f. Cancer, malignant tumour, malignant growth				
g. Gynaecological disorder such as, Dysfunctional Uterine Bleeding (DUB)/fibroid uterus/ovarian cyst.				
h. Disease of stomach, liver and gall bladder.				
i. Kidney diseases including kidney failure and renal stone.				
j. Disease of the urinary bladder and prostate				

k. Fistula, piles, Hernia, Varicose Veins.				
l. Any dimness of vision, cataract ?				
m. History of tonsillitis or any other disease or disorder of the Ear, Nose or Throat.				
n. Any dental problems ?				
o. Slipped disc, other spinal disorder or paralysis of any kind				
p. Any nervous, mental or psychiatric disease ?				
q. Any other illness or disease or accidents suffered by you ?				
r. Have you ever taken narcotics or other habit forming drugs or been treated or advised in connection with your alcohol consumption or taking of drugs ?				
S. Have any of these persons who proposed for insurance :				
1. Had any life/health/disability/cover declined/modified/postponed ?				
2. Had an ECG, X-Ray, blood/diagnotic test performed ?				
3. Has any medication been presctibed in the past 12 months ?				
4. Been advised surgery but not yet done				
5. Receiving payment for disability/illness/injury				
6. Had a change of weight in the past 6 months ?				
7. Been treated as in-patient or out-patient for surgery				
8. Had any medical treatment for mental or physical impairment ?				

Give particulars in table below of any other illness or disease or accident or operation sustained by you in the past

Nature of illness/diseases/ injury and treatment received	Date first treated	Name of attending medical practitioner/ surgeon with his address and Telephone Number	Whether fully cured
1.			
2.			
3.			
4.			

Family Physician's Name

Address

City/Taluk District State Pin Code

STD Code Phone No. Cell Regn. No.

6. ASSIGNMENT

In the event of death of the Insured Person, all the benefits that shall become payable under the policy will be paid to the person named as the 'Assignee' by the Insured Person and his/her receipt shall be sufficient discharge to the Company.

Sl.	Name of the Person Proposed	Name of the Assignee	Relationship	Signature of the Insured Person
1.				
2.				
3.				
4.				

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 prospectus or tables of the Insurers. 2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to five hundred rupees.

TO BE COMPLETED BY PROPOSER IN CASE OF ADVERSE HISTORY IN THE PROPOSAL FORM IN RESPECT OF APPLICABLE ILLNESS

Diabetes Questionnaire :

1. When was Diabetes Mellitus detected?	
2. Do you take any antidiabetic drugs? If so, give names with dose	
3. Please give details of Fasting and Postprandial Blood, Sugar Readings, ECG findings and other investigation reports. Please also send reports (Latest)	
4. Do you suffer or have suffered from any complication of diabetes mellitus?	

Hypertension Questionnaire :

1. What is your Blood Pressure reading?	
2. Please state names of antihypertensive drugs with dose.	
3. Is it Essential/Secondary	
4. Please state whether you have suffered from any complications from hypertension	
5. Please give findings of all investigation reports available	

Chest Pain or Coronary insufficiency or Myocardial Infarction Questionnaire :

1. Did you ever suffer from chest pain or coronary insufficiency or myocardial Infarction?, if so, please give diagnosis and date	
2. Please state the names and dose of drugs you are taking at present.	
3. Please state the findings with dates of investigations done like ECG, Stress test, coronary angiography, X-ray, pathology reports, etc. Please send reports with the proposal form.	
4. Please state the date of hospitalisation and names of hospitals and consultants.	
5. Please state whether you can do your regular work and whether you have any limitation of activity.	
6. Are you advised any special treatment? If so, please give information	

Place :
Date :

(For more than one person use photo copy)

Signature of the Proposer

TO BE COMPLETED BY CONSULTING PHYSICIAN/SURGEON (IN CASE OF ADVERSE MEDICAL HISTORY)

1. Name of the Proposer	
2. Relevant History (If necessary, please attach separate sheet)	
3. Details of present and past medication with duration	
4. General Examination	

Signature of Proposer :
Date :
Place :

Signature of Consulting Physician :
Name of Consulting Physican :
Qualifications & Address :

Declaration :

I hereby declare and warrant that the above statements are true and complete. I consent and authorise the insurers to seek medical information from any hospital/medical practitioner who has at any time attended or may attend concerning any disease or illness which affects my physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be effected. If after the insurance is effected it is found that the statements, answers or particulars stated in the proposal form and/or other questionnaire are incorrect or untrue in any respect the insurance company incur no liability under this policy.

I have read the prospectus and am willing to accept the coverage subject to the terms and conditions and expectations prescribed by the Insurance Company therein.

1. 3.

2. 4.

Dated

(Signature of the Proposer)

(This should be signed by the proposer. In case of minor, guardian or proposer may sign)

For Office use only :

Proposal Recd. on

Processed by Date

Approved by Date

Customer ID Policy No.