Proposal Form No.

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 Telefax : 044 - 28260062 Website : www.starhealth.in

PROPOSAL FORM

The company will not be on risk until the proposal has been accepted and full payment of premium has been made

Policy Issuing Office

Sales Manager		MT/ Agent:	
SM Code:		MT / Agent Code:	

Payment Details: Business Type ❑ Urban ❑ Rural.

Cash / Cheque No.		Dated:	Drawn on:	Payable at:
Proof of date of Birth	Birth Certificate / Voter ID / PAN Card / Driving License/ UID / Any other (Pl. Specify)		No. of the Proof	

Please Tick the Policy Opted	Mediclassic	Family Health Optima	Super Surplus	Health Gain	Criticare Plus

Please fill up the form in block letters. Also submit photographs of each of the person proposed for insurance for issuance of identity cards.

Name of the proposer :		
Address		
Mobile No	**Email ID:**	**IT PAN No:**
Period of Insurance From :	**To:**	

1	2	3	4	5
Affix Photographs	Affix Photographs	Affix Photographs	Affix Photographs	Affix Photographs

Sum Insured Opted (Please Tick)					Family Health Optima Plan (Please Tick)						
Rs. 1Lakh	Rs. 2Lakhs	Rs. 3 Lakhs	Rs.4 Lakhs	Rs. 5 lakhs	2A	1A + 1C	1A + 2C	1A + 3C	2A + 1C	2A + 2C	2A + 3C

Insured person details (Please fill in the respective column for each of the person proposed to be covered) :-

Sl.No	Name of the person proposed for insurance	Sex M / F	Relationship with proposer	Date of Birth	Sum Insured opted (Rs.)	Deductible Opted Rs.
1						
2						
3						
4						
5						

Family Physician's Name ____Phone No.________________________Regn No.________________________

Prohibition of rebates :(Section 41 of the Insurance Act) No person shall allow or offer to allow either directly or indirectly as inducement to take out 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 on the premium shown on the policy nor shall any person taking out renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer. Any person making default in complying with the provision of this section shall be punishable with fine, which may extend to five hundred rupees.

Place :

Date: Signature of the proposer

Acknowledgement

We acknowledge the receipt of your proposal along with your payment of Rs. ________/- vide Cash / Cheque No. __________, dated ____ , drawn on ___________ bank. Please note that the acceptance of the proposal is subject to the evaluation of the risk based upon the Medical examination report for which you will be referred by us to a hospital / laboratory. However, the cheque/cash given by you is banked for operational convenience and banking of the cheque/cash does not mean acceptance of risk by our self. The receipt of the cheque/cash will also be acknowledged by our office vide Advance Premium Receipt. If the proposal is accepted, the cover will commence from the date of the advance premium receipt subject to realization of the cheque. If the proposal is not acceptable, the amount paid will be refunded by our cheque.

Signature of the Insurer/Authorised Representative Signature of the Proposer

....Cut here..

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Signature of the Insurer/Authorised Representative Signature of the Proposer

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INSURED PERSON DETAILS (Contd…) Please fill in the respective columns for each of the person proposed to be covered

Details of other/previous insurance	1	2	3	4	5
1. Name of the Company					
2. Period of Insurance					
3. Sum Insured					
4. Policy No:					
Details of claims					
1. Ailment for which claim was made.					
2. Amount paid/rejected					
3. Year					
Health history – please provide answer in detail. A mere dash is not sufficient.					
1. Are you in good health and free from physical and mental disease of infirmity. If not give details.					
2. Have you ever suffered or suffering from any of the following :-					
a. Diabetes Mellitus.					
b. High BP, Heart disease					
c. Stroke, epilepsy, fainting attack, chronic headache.					
d. Tuberculosis, asthma, other respiratory infections.					
e. Any disease of bones/joints, slipped disc, spinal disorder					
f. Cancer, malignant tumor,					
g. Any gynecological disorder such as DUB, Fibroid Uterus, Ovarian cyst.					
h. Diseases of stomach, liver, gallbladder, kidney, urinary bladder and prostate.					
i. Fistula, piles, hernia, cataract. Disease / Disorder of Ear/Nose/Throat.					
j. Any other problem (Please specify)					
Have any of the persons proposed for insurance					
1.Had any medical test performed ?					
2. Medication prescribed ?					
3. Been advised surgery but not yet done?					
4. Receiving payment for any disability/injury/illness/disease					

Declaration: I hereby declare and warrant that the above statements are true and complete. I consent and authorize the insurer to seek any information regarding the medical history of the persons proposed from any medical establishment/medical practitioner/employer/any person. I agree that this proposal shall form the basis of the contract should insurance be effected. If it is found that the statements, particulars, declarations, connected documents or any other information provided in the proposal form are incorrect or untrue or there is failure to disclose any material particulars, the insurance company incur no liability under this policy. I have read the terms of this insurance and I am willing to accept the coverage provided by the Company.

Place

Date

Signature of the proposer

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