Star Health and Allied Insurance Co. Ltd.

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road,
Nungambakkam, Chennai - 600034.
Phone : 044 - 28288800 Telefax : 044 - 28260062 Website : www.starhealth.in

PORTABILITY FORM

PART I

1	**A. Details of Insured** Name of the Proposer	
2	Address of the Proposer	
3	Telephone No of the Proposer	
4	Mail ID of the Proposer	
5	Name of the Insured	
6	Age of the Insured (in completed years)	
7	**B. Details of the Proposed Insurance** i. Name of the Product to which porting is sought	
	ii. Sum Insured (Rs)	
	iii. Whether Cumulative Bonus is also to be converted to enhanced Sum Insured	
	iv. Total Sum Insured	
8	Reasons for Portability	
9	No of Family members to be included in the Policy to be ported	

Place :

Date : **Signature of the Policy Holder**

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PART I

C.Details of the Previous Insurer(s) & Policies

	Ist Year	IInd Year	IIIrd Year	IVth Year
Name of the Insurer				
Name of Product				
Policy No				
Customer ID (PAN / DL / PassPort / Aadhar Card)				
Period of Insurance				
Sum Insured (Rs)				
Cumulative Bonus, if any (Rs)				
Details of PED, if any				
Details of Claims Paid / Outstanding				
i. No of Claims				
ii. Amount				
iii. Nature of Illness for which claim has been mailed				

Note : Please provide copies of policies as proof for Previous Insurance.

Date:
Place:

Signature of the Policy Holder

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PART II

1. Whether the PED exclusions / time bound exclusions have longer exclusion period than the existing policy: (please indicate Yes / No)
2. If yes, please give written consent to the declaration below:

   "I am aware that the waiting period for the following disease(s) / treatment(s) is _____ days / years more than the previous terms. I hereby agree to observe the additional waiting period for the following disease(s) / treatment(s)"

Date :

Place : **Signature of the Policy Holder**

PART III

I understand that my proposal to cover the person under portability is considered by Star Health & Allied Insurance Co. Ltd based on the details furnished by me in the proposal form & portability form and I declare that the details furnished are true & correct. In the event of the details furnished by me is at variance from the details that will be obtained from my previous Insurer under the portability system, my policy will be cancelled or will be subject to endorsements amending the scope of cover at the discretion of Star Health & Allied Insurance Co. Ltd.

I have asked for an increase in sum insured and I understand and agree that the enhanced sum insured that is being given on my request will not be available for any illness, diseases, injury already contracted under the preceding policy period.

Place :

Date : **Signature of the Policy Holder**

For Office Use Only:

Documents submitted along with Proposal Form

1. Previous Years Policies
2. Renewal Notice
3. Medical Reports, if applicable
4. Proposal Form