

Details of the person proposed for insurance		Insured Person - 1		Insured Person - 2		Insured Person - 3		Insured Person - 4		Insured Person - 5		
Name												
Gender	Date of Birth	M / F / Thirdgender	DD/MM/YYYY	M / F / Thirdgender	DD/MM/YYYY	M / F / Thirdgender	DD/MM/YYYY	M/F/Thirdgender	DD/MM/YYYY	M/F/Thirdgender	DD/MM/YYYY	
Height (cms)	Weight (kgs)	CMS	KGS	CMS	KGS	CMS	KGS	CMS	KGS	CMS	KGS	
Relationship with proposer												
Occupation	Annual Income (Rs.)											
Do you want Gold Plan [Applicable for MediClassic Insurance Policy (Individual)]		YES/NO		YES/NO		YES/NO		YES/NO		YES/NO		
Sum Insured Opted (Rs.)												
Add-ons : [Applicable for MediClassic 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.)		Hospital Cash	Patient Care	Hospital Cash	Patient Care	Hospital Cash	Patient Care	Hospital Cash	Patient Care	Hospital Cash	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. Ailment for which Claim was made		Year	YYYY	YYYY	YYYY	YYYY	YYYY	YYYY	YYYY	YYYY	
	2. Claim Amount Paid / Rejected											
Health History : Please provide answer in detail. A mere dash is not sufficient.		Family Physician's Name		Phone		Regn No						
1. Is the person proposed for insurance in good health and 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 for? (answer if applicable) - If Yes provide details.												
j) Disease of Stomach, Intestine, Liver, Gall bladder / Pancreas, Kidney, Urinary bladder, Urinary Tract Diseases - If Yes, since when												
k) Disease of Prostrate / 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)												
Applicable for Star Comprehensive Insurance Policy												
8. Does the Insured Occupation require to engage in manual labour ?												
9. 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												
10. Name of the family member chosen for Personal Accident Insurance under Section-7 (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. Personal Accident cover is not available for dependent children and for persons above 70) years												
Declaration of the Agent/ Intermediary: I / 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 :		Name of the Agent / Specified Person of Corporate Agent / Authorised Employee of the Broker / Insurance Sales Person of the IMF		Signature :								



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 _____.

Date : _____ Place : _____

Name & Code of the authorised person : _____

Signature of the authorised person [Signature Box]

Common Proposal Form

Policy selection options: FAMILY HEALTH OPTIMA INSURANCE PLAN, MEDICLASSIC INSURANCE POLICY (INDIVIDUAL), SENIOR CITIZENS RED CARPET HEALTH INSURANCE POLICY, STAR COMPREHENSIVE INSURANCE POLICY, STAR CRITICARE PLUS INSURANCE POLICY, STAR HEALTH GAIN INSURANCE POLICY, STAR FAMILY DELITE INSURANCE POLICY. Includes sum insured options and family size selection.

Photograph affixation boxes for Insured Person - 1 through Insured Person - 5.

Name : _____ Name : _____ Name : _____ Name : _____ Name : _____

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 and 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.

Submitted the above proposal for _____ policy along with payment of Rs. _____ / by cash/vide cheque /DD no _____ dated _____ drawn on _____.

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 : [Signature Box]

Table with 4 columns: Date, Name of the person who explained, Signature of the person who explained, Signature / Thumb impression of the proposer. Includes text: '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.'

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.

PRO / COMMON / V.3 / 2019

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Common Proposal Form

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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.: SHAH/PR0002
Policy No.: _____
Policy Issuing Office: _____
SM CODE, AGENT CODE, SPECIFIED PERSON CODE, SM NAME, AGENT NAME, SPECIFIED PERSON NAME

BUSINESS TYPE
Rural Sector Classification (This classification is based upon the address of the proposer):
a. Unorganised Sector
b. Economically Vulnerable or Backward Classes
c. Internally Vulnerable or Backward Classes
d. Informal Sector

Name of the Proposer: _____ Date of Birth: _____
Occupation of the Proposer: _____ Annual Income Rs.: _____
Residence Address: _____
Office Address: _____
Email ID: _____ Mobile Number: _____
Pin Code: _____

PERIOD OF INSURANCE
From: _____ To: _____
GST Number: _____ PAN Number: _____

NOMINATION
Nominee's Name: _____ Date of Birth: _____
Relationship to the Proposer: _____ Relationship to the Nominee: _____
Name of the Appointee (if nominee is a minor): _____ Age: _____

Incense of Multiple nominees a separate form containing nominee details should be enclosed duly specifying the % to each nominee.
I would like to receive my insurance policy and all the information related to the proposed insurance policy through insurance repository: Yes No

Bank Details
Name of the Bank: _____ Name of the Branch: _____ IFSC Code: _____
Account Number: _____ Type of Account: SB CA Others please specify

Payments Details
Annual Premium Rs. _____ Mode of Payment: Cash / Cheque / DD / Credit Card / Debit Card / NEFT / CC Mandate
Cheque / DD No.: _____ Date: _____ Drawn on: _____ Branch: _____

Proposal Form No. :

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