



Ref. No.: \_\_\_\_\_

Policy No.: \_\_\_\_\_

PLEASE FILL UP THE FORM IN BLOCK LETTERS

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

Policy Issuing Office  	SM CODE	
	SM NAME	
	AGENT / CORPORATE AGENT / BROKER / IMF / POSP / CODE	
	AGENT / CORPORATE AGENT / BROKER / IMF / POSP / NAME	
POSP PAN NUMBER		POSP GST NUMBER
<b>PROPOSER DETAILS</b>		

Please affix Passport size photograph of the Proposer

Prefix	First Name	Middle Name	Last Name
Proposer Name (same as KYC/ID proof)			
Father / Spouse Name			
Mother Name			
Date of Birth	D D M M Y Y Y Y	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/>
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 (please tick) <input type="checkbox"/>	Unorganized Sector <input type="checkbox"/> Economically Vulnerable or Backward Classes <input type="checkbox"/> Other Categories of Persons <input type="checkbox"/> Informal Sector <input type="checkbox"/>	Are you a ASHA worker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Are you a MGNREGA worker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

\* "Social Sector" includes unorganised sector, informal sector, economically Vulnerable or backward classes and other categories of persons, both in rural and urban areas; (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.(b)"Economically Vulnerable or Backward Classes" means persons who live below the poverty line. (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. (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.

Source of Income	<input type="checkbox"/> Salaried <input type="checkbox"/> Business <input type="checkbox"/> Others, please specify _____	Proof of Income to be submitted	<input type="checkbox"/> IT Returns <input type="checkbox"/> 3mths Payslip <input type="checkbox"/> Other Proof, please specify _____
Annual Income (in Rs.) :	PAN Number†	If PAN number is not available submit Form 60†	
GST Number		Residential Status	<input type="checkbox"/> Indian Resident <input type="checkbox"/> NRI <input type="checkbox"/> PIO <input type="checkbox"/> Foreign National
CKYC Number		Email ID	
Do you wish to update CKYC with the KYC details provided here	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you (Proposer) or any of the insured person is a PEP (Politically Exposed Person) or related to PEP†††	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details
Overseas Address	Address line 1	Permanent Address (should be same as address Proof)	Address line 1
	Address line 2		Address line 2
	City / Town / Village		City / Town / Village
	District		District
	State		State
	Country and Pincode		Country and Pincode
	Overseas Mobile No.		Mobile No. while in India
Please attach any one proof in support of ID and Address†	<input type="checkbox"/> Voter ID <input type="checkbox"/> Driving License Exp Dt.: _____	<input type="checkbox"/> Aadhar Card <input type="checkbox"/> Passport Exp Dt.: _____	<input type="checkbox"/> NREGA Job Card <input type="checkbox"/> Any Other Govt. Notified Document
Nomination	Nominee's Name :	Relationship to Proposer :	Date of Birth D D M M Y Y Y Y Age in yrs
	Name of the Appointee (if nominee is a minor) :	Relationship to Nominee :	Date of Birth D D M M Y Y Y Y Age in yrs
(Incase of Multiple nominees a separate form containing nominee details should be enclosed duly specifying the % to each nominee)		Do you wish to receive the copy of the policy document by Email / Whatsapp / Any other electronic mode <input type="checkbox"/> Yes <input type="checkbox"/> No	
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	If you already have an e-Insurance Account (eIA) number, please provide:	If you don't have an (eIA) number, please choose any one Insurance Repository
		Kary Insurance Repository Limited	CAMS Insurance Repository Services Limited
		CDSL Insurance Repository Limited	NSDL National Insurance Repository (NIR)
Period of Insurance	From D D M M Y Y Y Y	To	D D M M Y Y Y Y

†The copy of PAN card or Form 60 is mandatory | ††If CKYC number is provided, proof of submission is not mandatory | †††Politically Exposed Persons (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, example, Heads of State or of Governments, senior politicians, senior government / judicial / military officials, senior executives of state owned corporations, important political party officials, etc., including their family members and close relatives.

**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 : L66010TN2005PLC056649 | IRDAI Regn. No. : 129

<b>Star Travel Protect Insurance Policy</b> Unique Identification Number: IRDA/NL-HLT/SHAI/P-TV./I/140/13-14	<b>Star Corporate Travel Protect Insurance Policy</b> Unique Identification Number: IRDA/NL-HLT/SHAI/P-TV./I/143/13-14	<b>Star Student Travel Protect Insurance Policy</b> Unique Identification Number: IRDA/NL-HLT/SHAI/P-TV./I/142/13-14	<b>POS - Star Travel Protect Insurance Policy</b> Unique Identification Number: IRDA/NL-HLT/SHAI/P-TV./I/140/13-14
<b>Plan Type (Tick your Option)</b>		<b>Plan Type (Tick your Option)</b>	
Including USA And Canada	Excluding USA And Canada	Including USA And Canada	Excluding USA And Canada
PLAN A1 : USD50000 <input type="checkbox"/>	PLAN A2 : USD50000 <input type="checkbox"/>	CTP 1 : USD 100000 <input type="checkbox"/>	<input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Standard
PLAN B1 : USD100000 <input type="checkbox"/>	PLAN B2 : USD100000 <input type="checkbox"/>	CTP 2 : USD 250000 <input type="checkbox"/>	STP 1 : USD50000 <input type="checkbox"/>
PLAN C1 : USD250000 <input type="checkbox"/>	PLAN C2 : USD250000 <input type="checkbox"/>	CTP 3 : USD 500000 <input type="checkbox"/>	STP 2 : USD100000 <input type="checkbox"/>
PLAN D1 : USD500000 <input type="checkbox"/>	PLAN D2 : USD500000 <input type="checkbox"/>	Trip band : 30 days <input type="checkbox"/> 45 days <input type="checkbox"/>	STP 3 : USD250000 <input type="checkbox"/>

**Important:** The coverage varies from plan to plan. Please check brochure / sales literature or our website: www.starhealth.in for detail.

**Bank Details of the Proposer**

<b>Mode of Payment</b>	<input type="checkbox"/> Cheque <input type="checkbox"/> DD <input type="checkbox"/> Debit Card <input type="checkbox"/> Credit Card <input type="checkbox"/> NEFT <input type="checkbox"/> ECS	<b>Premium Amount</b>	Rs.		Account Number : _____ Name of the Bank : _____ Name of the Branch : _____ IFSC Code : _____	<b>Payment Details</b>	Cheque / DD No. : _____ Date : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	<input type="checkbox"/> CC Mandate <input type="checkbox"/> Cash <i>(Cash payments are not eligible for the 80D tax benefits)</i>		<b>Type of Account</b>	<input type="checkbox"/> Savings Account <input type="checkbox"/> Current Account			<b>Others Please Specify</b>

Details of the person proposed for insurance	Insured Person - 1	Insured Person - 2	Insured Person - 3	Insured Person - 4	Insured Person - 5
<b>Name</b>					
<b>Gender</b>	M / F / Transgender	M / F / Transgender	M / F / Transgender	M / F / Transgender	M / F / Transgender
<b>Date of Birth</b>	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
<b>Height (cms)</b>	CMS	CMS	CMS	CMS	CMS
<b>Weight (kgs)</b>	KGS	KGS	KGS	KGS	KGS
<b>Relationship with proposer</b>					
<b>Sum Insured Opted (For Individual Policy) (Rs.)</b>					
<b>Passport Number</b>					
<b>Passport Expiry Date</b>	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
<b>Do you have any health Insurance policy with us? If Yes Provide details</b>					
<b>Health History: Please provide answer in detail, specific diagnosis and treatment details A mere dash is not sufficient</b>	Family Physician's Name: _____ Phone: _____ Regn No: _____				
1) Is the person proposed for insurance suffering or has ever suffered from any illness / disease up to the time of making this proposal?	<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
If Yes Please Specify _____	If Yes Please Specify _____	If Yes Please Specify _____	If Yes Please Specify _____	If Yes Please Specify _____	If Yes Please Specify _____
<b>2. Has the person proposed for insurance ever suffered or suffering from any of the following</b>					
a) Diabetes Mellitus – if yes mention date of diagnosis, Type and medication details					
b) High BP / Cholesterol – if yes mention date of diagnosis, medication details					
c) Thyroid disorders ,specify diagnosis Hypo / Hper thyroid / Autoimmune thyroiditis), mention date of diagnosis, medication details					
d) Heart and vascular disease – if yes mention date of diagnosis, medication details, Intervention done, CAG, PTCA, CABG, others)					
e) Osteoporosis - If Yes since when					
f) Disease of bones / joints, slipped disc, spinal disorder, injury to ligaments – if yes mention date of diagnosis, operated or treatment details					
g) Any other problem please specify					
3. Do you have any physical defect or deformity?					
4. Have you ever been hospitalized for treatment / observation? If so, please furnish details.					
5. Are you currently or in the past on Medication? Please furnish details					
6. Have you suffered from any illness or had an Accident in the preceeding 12 Months?					
7. Have you recently (within 60 days) taken any health check-up - If yes please attach report					
<b>8. Travel Details</b>					
a) Does your trip include USA and/or CANADA	<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

b) Countries to be visited					
c) How Frequently do you travel overseas?					
d) Date of Departure from India					
e) Proposed date of return to India					
f) No. of days					
g) Purpose of Visit	<input type="checkbox"/> Business / <input type="checkbox"/> Holiday / <input type="checkbox"/> Study	<input type="checkbox"/> Business / <input type="checkbox"/> Holiday / <input type="checkbox"/> Study	<input type="checkbox"/> Business / <input type="checkbox"/> Holiday / <input type="checkbox"/> Study	<input type="checkbox"/> Business / <input type="checkbox"/> Holiday / <input type="checkbox"/> Study	<input type="checkbox"/> Business / <input type="checkbox"/> Holiday / <input type="checkbox"/> Study
	<input type="checkbox"/> Others (Please Specify) _____	<input type="checkbox"/> Others (Please Specify) _____	<input type="checkbox"/> Others (Please Specify) _____	<input type="checkbox"/> Others (Please Specify) _____	<input type="checkbox"/> Others (Please Specify) _____
h) Nature of Visa					

**9. Additional Information to be Completed by the Student (only for Star Student Travel Protect)**

a) Name of the Student	Date of Birth	DD/MM/YYYY			
b) Name of the Institution where the student proposed to study					
c) I-20 Number /Attach copy of admission letter as applicable					
d) Detailed address of the Institution/Telephone No. & Name of the contact person at the institution					
e) Tuition fees per Semester: (Please give the detailed breakup)					
f) Tuitions financed by: Self / parents / borrowing from bank or FI's / please give details					
g) Internship Period					
h) Have you undergone medical examination / fitness test? If yes attach report					
i) If sponsored by persons / bodies other than above					
a) Name of the Sponsor					
b) Address / Phone No. / E-mail Id					
j. Please Provide Course Details					
a) Course Duration					
b) Date of commencement	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
c) Date of conclusion	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
d) Number of Semesters					
10. Would like to state any thing that is not asked which you may want the insurer to know ?					

11. Type and total number of medical documents provided					
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)					
Date		Code		Name of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF / POSP	Signature of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF / POSP

**Medical History of the proposer to be completed by M.D. Cardiologist (Mandatory for above 65 years and all age groups having diagnosed with heart ailments)**

a) Past Medical History (diagnosis / treatment / surgery)				
b) Current health status				
c) Details of active (hospitalisation / day care) surgical or medical intervention required to address the health status				
d) From the Lab reports ECG, Fasting and Post Prandial Blood Sugar Report, Creatinine, Complete Urine Examination, liver function test, do you consider that the Proposer is fit to undertake travel abroad?				

Signature of the Doctor with Date and Registration Number

**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 policy start date as stated in the policy schedule, 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.

**Date:** \_\_\_\_\_ **Place:** \_\_\_\_\_ **Name & Code of the authorised person:** \_\_\_\_\_ **Signature of the authorised person:** \_\_\_\_\_

**Common Proposal Form For Overseas Travel Insurance**

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
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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.

**Declaration**

The primary duty of the proposer is to fill out the proposal form and also to make sure that the proposal contains all the details correctly. If you or any of the insured person(s) have suffered or suffering from any of the diseases which has not been mentioned in the proposal, the claim that may arise will result in a repudiation of the claim/cancellation of the policy.

I/we agree that the PAN details and other information provided by me/us in the proposal form may be used by the Company to download/ verify / modify / add my/our KYC documents from the CERSAI\* CKYC portal for processing this application. I/We understand that only the acceptable officially valid documents would be relied upon for processing this application. (\*Central Registry of Securitization and Asset Reconstruction and security Interest of India) I hereby consent to receiving information from Central KYC Registry through SMS / email on the above registered number/email address.

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 NCPDR.

Place	Date	Name	Signature / Thumb impression of the proposer:

**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

The contents of the proposal form and features of the product have been fully explained to me and I have fully understood the significance of the proposed contract.

Signature / Thumb impression of the proposer
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**Prohibition of Rebates: Section 41 of Insurance Act 1938.**

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 published prospectuses or tables of the insurer.
2. 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.

Beware of spurious phone calls and fictitious/fraudulent offers and never respond to calls/emails/embedded links in SMS/emails asking you to update User id/Password/Credit Card Number/CVV/OTP etc. Insurance is a contract of the utmost good faith, requiring the insured to answer all of the questions on the proposal form honestly and without omitting any information that is relevant. When submitting the proposal form, kindly reveal all pertinent information. If any important information is omitted from the proposal form, personal statement, declaration, or related papers, or if the proposer or someone acting on his behalf makes any false or erroneous statements, misrepresentations, or omissions, the Policy will be invalid, at the insurer's discretion. Please get in touch with the company's offices or agents if you have any questions about the proposal form.