STAR Health Insurance — Personal & Caring — The Health Insurance Specialist

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.

Special Care Gold, Star Health and Allied Insurance Company Limited
Unique Identification No.: SHAHLIP23182V012223

Policy Issuing Office

SM CODE	
SM NAME	
AGENT / CORPORATE AGENT / BROKER / IMF / POSP / MICRO AGENT CODE	
AGENT / CORPORATE AGENT / BROKER / IMF / POSP / MICRO AGENT NAME	

Please affix Passport size photograph of the Proposer

POSP PAN NUMBER | POSP GST NUMBER

PROPOSER DETAILS

	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 | Female | Transgender | Occupation

Business Type

Do you come under below mentioned Social Sector Classification* ☐ Yes ☐ No

If Yes (please tick): ☐ Unorganized Sector ☐ Economically Vulnerable or Backward Classes ☐ Other Categories of Persons ☐ Informal Sector

Rural and Social Sector Classification

Are you a ASHA worker ☐ Yes ☐ No

Are you a MGNREGA worker ☐ Yes ☐ No

* "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 ☐ Salaried ☐ Business ☐ Others, please specify _____ | Proof of Income to be submitted ☐ IT Returns ☐ 3mths Payslip ☐ Other Proof, please specify _____

Annual Income (in Rs.) : | PAN Number† | If PAN number is not available submit Form 60† ☐

GST Number | Residential Status ☐ Indian Resident ☐ NRI ☐ PIO ☐ Foreign National

CKYC Number | Email ID

Do you wish to update CKYC with the KYC details provided here ☐ Yes ☐ No | Are you (Proposer) or any of the insured person is a PEP (Politically Exposed Person) or related to PEP††† ☐ Yes ☐ No | If yes, please provide details _____

Current 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
	Mobile Number			Alternate Mobile Number

Please attach any one proof in support of ID and Address†† ☐ Voter ID ☐ Driving License Exp Dt.: ☐ Aadhar Card ☐ Passport Exp Dt.: ☐ NREGA Job Card ☐ 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 ☐ Yes ☐ No

I would like to receive my insurance policy and all the information related to the proposed insurance policy through insurance repository ☐ Yes ☐ 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: ☐ Karvy 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)

Do you want to pay the premium in Instalments ☐ Yes ☐ No | If yes (Please choose Instalment option) ☐ Quarterly ☐ Halfyearly

†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.

Sum Insured Options		Rs.4,00,000/-		Rs.5,00,000/-	Mode of Payment	☐ Cheque ☐ Debit Card ☐ ECS ☐ NEFT ☐ DD ☐ Credit Card ☐ CC Mandate ☐ Cash *(Cash payments are not eligible for the 80D tax benefits)*	
Waiver of Co-payment Opted		Yes		No	Bank Details of the Proposer	Account Number _____ Type of Account: ☐ Savings Account ☐ Current Account ☐ Others Please Specify _____	Name of the Bank : _____ Name of the Branch : _____ IFSC Code : _____
Premium Amount Rs.					Payment Details	Cheque / DD No. : Date : D D M M Y Y Y Y Branch :	Please attach a photo copy of cancelled cheque leaf

Details of the person proposed for insurance		Insured Person - 1	
Name			
Gender	Date of Birth	M / F / Transgender	DD/MM/YYYY
Height (cms)	Weight (kgs)	CMS	KGS
Relationship with proposer			
Occupation	Annual Income (Rs.)		
Ayushman Bharat Health Account (ABHA) No.			
Sum Insured Opted (For Individual Policy) (Rs.)			
Existing "Person with Disability or HIV/AIDS" Insurance Coverage with us and/or 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
	2. Claim Amount Paid / Rejected		

Family Physician's Name: _____ Phone: _____ Regn No: _____

Note : If any of the below mentioned questions from "1 to 8" is "YES" and if additional space is needed to provide medical condition in detail, please enclose a seperate sheet along with this proposal form.

1. Do you suffer from HIV/AIDS	☐ Yes / ☐ No
a. If Yes, please mention and enclose a recent certificate of your current Cd4 count (within past 30 days)	
b. Has your CD4 count gone below 350 in the past 4 years	☐ Yes / ☐ No
c. If Yes, when and how many times	
2. Do you suffer from any disability	☐ Yes / ☐ No
a. If Yes, please mention and enclose a recent certificate provided by the certifying authority	
3. Has the person proposed for insurance consulted / diagnosed / taken treatment / been admitted for any illness / injury other than Disability or HIV AIDS. If yes, give details	
4. Has the person proposed for insurance ever suffered or suffering from any of the following	
a) Diabetes Mellitus –if yes, mention the duration/date of diagnosis, Type and medication details.	
b) High BP/ Cholesterol – if yes, mention duration/date of diagnosis and medication details	

c) Thyroid disorders, specify diagnosis Hypo / Hyperthyroid / Autoimmune thyroiditis, Goitre etc), duration/date of diagnosis and medication details	
d) Heart and vascular disease / Arrhythmias / valvular diseases / Cardiomyopathy – if yes, mention duration/date of diagnosis, medication details, Intervention done, CAG, PTCA, CABG and others)	
e) Stroke, epilepsy, fainting attack, chronic headache, Parkinson's disease, Alzheimer's disease, mental disease or infirmity? – if yes, mention the duration/date of diagnosis and medication details	
f) Tuberculosis, asthma, COPD, ILD, other respiratory diseases if yes, mention – duration/date of diagnosis and medication details	
g) Disease of bones/joints, slipped disc, spinal disorder, injury to ligaments – if yes, mention duration/date of diagnosis and operation or treatment details	
h) Whether diagnosed to have arthritis (Rheumatoid / Osteo arthritis or any other inflammatory arthritis like Ankylosing spondylitis). If yes, mention treatment details and submit all records	
i) Gynecological disorder such as menstrual irregularity (DUB), fibroid uterus, ovarian cyst- or have undergone cesarean / hysterectomy – if yes, mention duration/date of diagnosis and medication details	
j) Disease of stomach, intestine, liver, gall bladder / Pancreas, Piles / Fistula / Fissure / Hernia if yes, mention duration/date of diagnosis and medication details	
k) Disease of kidney, urinary bladder, urinary tract disease, Calculi- if yes, duration/date of diagnosis and medication details	
l) Disease of prostate / hydrocele / genital disease / - if yes, mention duration/date of diagnosis and medication details	
m) Diseases of the eye, Cataract / corneal / retinal, other disorders and Ear, Nose Throat disease –if yes, mention duration/date of diagnosis and medication details	
n) Cancer, Precancerous lesions, Non-healing ulcers – if yes, mention type of cancer, duration/date of diagnosis and treatment details	
o) Any blood disorder, specify the diagnosis, mention duration/date of diagnosis and medication details	
p) Any autoimmune disease / any long-term steroid / Immunosuppressant intake like myasthenia gravis / SLE / Psoriasis, Ulcerative Colitis, Crohn's disease etc.) duration/date of diagnosis and medication details.	
q) Any other Health problems/diseases please specify	
5. Do you suffer from any pre-existing illness other than Disability or HIV AIDS mentioned above	☐ Yes / ☐ No
a. If Yes, please specify details and the number of years you are suffering	
6. Any other previous medical details other than Disability or HIV AIDS	
7. Does the person proposed for insurance has any of the mentioned habits	
a) Chew Tobacco - If yes, since when	
b) Smoke - If yes, since when	
c) Consume Alcohol - If yes, since when	
d) If a, b and c, are mentioned as yes, mandatory to give details whether diagnosed with any local or systemic disease / complications.	
8. Type and the 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 / Micro Agent	Signature of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF / POSP / Micro Agent

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Acknowledgement

Received the proposal for **Special Care Gold, Star Health and Allied Insurance Company Limited** 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:**

Please affix stamp size photograph of Insured Person

Only one Policy is allowed for one person

Submitted the above proposal for **Special Care Gold, Star Health and Allied Insurance Company Limited** 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, which includes sharing of my medical data through ABHA. 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 NCPR.

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

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.