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

Family Health Optima Accident Care Policy
(Proposal Form - Unique Reference no: SHAI/PR0007A)

Medi Classic Accident Care Individual Insurance Policy
(Proposal Form - Unique Reference no: SHAI/PR0007B)

Ref. No.	
Policy No.	

The company will not be on risk until the proposal has been accepted and full payment of premium has been received. Please fill up the form in block letters.

Policy Issuing Office:	SM CODE		SM NAME	
	AGENT / CORPORATE AGENT / BROKER / IMF / CODE		AGENT / CORPORATE AGENT / BROKER / IMF / NAME	

Name of the Proposer Mr / Mrs / Ms.		Date of Birth:
Occupation of the Proposer		Annual Income Rs.:

Residencial Address:	Pin Code:	Office Address:	Pin Code:

Mobile Number		Email ID	
PAN Number		GST Number	

BUSINESS TYPE

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

If Yes: ☐ a. Unorganized Sector ☐ b. Other Categories of Persons ☐ c. Economically Vulnerable or Backward Classes ☐ d. Informal Sector

Rural and Social Sector Classification		
Are you a ASHA workers	❑ Yes	❑ No
Are you a MGNREGA workers	❑ 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.

Period of Insurance	From		To	

NOMINATION

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

(Incase of Multiple nominees a separate form containing nominee details should be enclosed duly specifying the % to each nominee)

Please Tick (✓) the Policy Opted

☐ FAMILY HEALTH OPTIMA ACCIDENT CARE POLICY
UIN No.: SHAHLIP21240V042021

☐ MEDI CLASSIC ACCIDENT CARE (INDIVIDUAL) INSURANCE POLICY
UIN No.: SHAHLIP21241V052021

Sum insured available under health Section I of Family Health Optima Accident Care Policy (Rs.)	❑ 3,00,000/-	❑ 4,00,000/-	❑ 5,00,000/-	❑ 10,00,000/-	❑ 15,00,000/-	❑ 20,00,000/-	❑ 25,00,000/-
Sum insured options available under Health Section I of Mediclassic Accident Care Individual Insurance Policy (Rs.)	❑ 1,50,000/-	❑ 2,00,000/-	❑ 3,00,000/-	❑ 4,00,000/-	❑ 5,00,000/-	❑ 10,00,000/-	❑ 15,00,000/-
Sum insured options Available in Gold Plan under Section I of Mediclassic Accident Care Individual Insurance Policy (Rs.)	❑ 3,00,000/-	❑ 4,00,000/-	❑ 5,00,000/-	❑ 10,00,000/-	❑ 15,00,000/-	❑ 20,00,000/-	❑ 25,00,000/-

Applicable for Family Health Optima Accident Care Policy (A=Adult, C=Child)	❑ 1A+1C	❑ 1A+2C	❑ 1A+3C	❑ 2A	❑ 2A+1C	❑ 2A+2C	❑ 2A+3C

Add-on covers available under Mediclassic Accident Care Insurance Policy (Individual)	❑ Hospital cash	❑ Patient care

I would like to receive my insurance policy and all the information related to the proposed insurance policy through insurance repository	■ YES	■ NO	Do you wish to receive the physical copy of the policy document	■ YES	■ NO

If you already have an e-Insurance Account (eIA) number, kindly provide e-Insurance Account (eIA) number: _____

If you don't have an (eIA) number, choose any one Insurance Repository

■ KARVY ■ CAMSRep - CAMS Insurance Repository & Services
■ CIRL - Central Insurance Repository Limited ■ NDML - NSDL Data Management Services limited

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

Please attach a photo copy of cancelled cheque leaf of the above Bank Account.

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

Please attach any one proof of Date of Birth : ❑ Birth Certificate ❑ Voter ID ❑ PAN Card ❑ Driving License ❑ Aadhar Card ❑ Any other Govt. Recognised Proof

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 (For Individual Policy) (Rs.)											
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
	2. Claim Amount Paid / Rejected										
For Accident Section											
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.										
	5. Details of claim if any										
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 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					
6. Does the person proposed for insurance — b) Smoke - If Yes, since when					
6. Does the person proposed for insurance — 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)					
8. Does the Occupation require the person proposed for insurance to engage in manual labour?					
9. Do person proposed for insurance engage in any activity or sport which is hazardous or adventurous in nature such as Racing, Mountaineering, Winter sport, etc., if so please specify					

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 / Broker Qualified Person / Insurance Sales Person of the IMF /	Signature of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Acknowledgement

Proposal Form No.:

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 date of the collection receipt, 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:**

Family Health Optima Accident Care Policy / Medi Classic Accident Care Individual Insurance Policy

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

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 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 NCPR.

Submitted the above proposal for _____ 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:

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.