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 FOR OVERSEAS TRAVEL INSURANCE

Proposal Form - Unique Reference No.: SHAI/PR0020

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. Also submit photographs of each of the person proposed for insurance for issuance of identity cards

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**	DD/MM/YYYY
Occupation of the Proposer		**Annual Income**	Rs.
Name of the Insured Mr / Mrs / Ms.		**Date of Birth**	DD/MM/YYYY
Occupation of the Insured		**Relationship to the Proposer**	

Passport Number	India	**Mobile No. while in India**		**Mobile No. / Any other while Overseas**	
Passport Expiry Date	DD/MM/YYYY				
Email ID				**Height** Cms	**Weight** Kgs

Residencial Address:	**Overseas Address:**
Pin Code:	**Pin Code:**
GST Number	**PAN 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 the Proposer		**Date of Birth**	DD/MM/YYYY	**Age**	Yrs
Name of the Appointee (if nominee is a minor)		**Relationship to the Nominee**		**Age**	Yrs

(Incase 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	**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

STAR TRAVEL PROTECT INSURANCE POLICY UID No.: IRDA/NL-HLT/SHAI/P-T/V.I/140/13-14				STAR CORPORATE TRAVEL PROTECT INSURANCE POLICY UID No.: IRDA/NL-HLT/SHAI/P-T/V.I/143/13-14		STAR STUDENT TRAVEL PROTECT INSURANCE POLICY UID No.: IRDA/NL-HLT/SHAI/P-T/V.I/142/13-14	
PLAN TYPE (TICK YOUR OPTION)				PLAN TYPE (TICK YOUR OPTION)		PLAN TYPE (TICK YOUR OPTION)	
INCLUDING USA AND CANADA		EXCLUDING USA AND CANADA					
PLAN A1 : USD 50000	☐	PLAN A2 : USD 50000	☐	CTP 1 : USD 100000	☐	STP 1 : USD50000	☐
PLAN B1 : USD 100000	☐	PLAN B2 : USD 100000	☐	CTP 2 : USD 250000	☐	STP 2 : USD100000	☐
PLAN C1 : USD 250000	☐	PLAN C2 : USD 250000	☐	CTP 3 : USD 500000	☐	STP 3 : USD250000	☐
PLAN D1 : USD 500000	☐	PLAN D2 : USD 250000	☐	Trip band : 30 days ❑ 45 days ❑			

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

TRAVEL DETAILS			
1) Does your trip include USA and / or CANADA	☐ YES ☐ NO		
2) Countries to be visited			
3) How Frequently do you travel overseas?			
4) Date of Departure from India			
5) Proposed date of return to India			
6) No. of Days			
7) Purpose of Visit	☐ Business	☐ Holiday	☐ Study
	☐ Others (Please Specify) _____		
8) Nature of Visa			
9) Do you have any health Insurance policy with us? If Yes Provide details			

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			
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

Important: No refund of premium is permissible in case you return to India before the expiry date. In case of any extension of stay abroad necessitating extension of Policy period, approval of issuing office must be obtained and appropriate premium paid before expiry of policy. Request for such extension should be supported with a declaration of good health. and to be sent to policy issuing on office atleast 7 days prior to the policy expiry date.

FAMILY PHYSICIAN DETAILS			
Family Physician Name		Address:	
Regn. No			
Qualification			
Telephone No		E-mail ID	

Medical History (Please answer these questions clearly, completely and truthfully. Failure to do so may prejudice your claim)	
Is the person proposed for insurance suffering or has ever suffered from any illness/ disease up to the time of making this proposal?	☐ YES ☐ NO, If Yes Please Specify _____
1. Has the person proposed for insurance ever suffered or suffering from any of the following	
a) Diabetes Mellitus - If Yes, since when	
b) Hypertension - If Yes, since when	
c) Heart Disease - If Yes, since when	
d) Osteoporosis - If Yes since when	
e) Disease of bones / joints - If Yes, since when	
g) Any Other Problem (Please Specify)	
2. Do you have any physical defect or deformity?	
3. Have you ever been hospitalized for treatment/ observation? If So, please furnish details.	
4. Are you currently or in the past on Medication ? Please furnish details.	
5. Have you suffered from any illness or had an Accident in the preceeding 12 Months?	
6. Have you recently (within 60 days) taken any health check-up. - If yes please attach report	

Medical History of the proposer to be completed by M.D. Cardiologist	
1. Medical History	
2. Any Past History of Disease suffered / surgery undergone	
3. How frequently the proposer would visit you for advice/treatment?	
4. From the Lab reports ECG, Fasting and Post Prandial Blood Sugar Report, Urine Strip Report and Cholestrol Profile, do you consider that the Proposer is fit to undertake travel abroad?	

Date	
Signature of the Doctor with Registration Number	

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Acknowledgement

Received the proposal for _____ 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:**

ADDITIONAL INFORMATION TO BE COMPLETED BY THE STUDENT (ONLY FOR STAR STUDENT TRAVEL PROTECT)

Name of the Student		Tuition fees per Semester: (Please give the detailed breakup)	
Date of birth		Tuitions financed by: Self / parents / borrowing from bank or FI's / please give details	☐ YES ☐ NO
Name of the Institution where the student proposed to study		Internship Period	
I-20 Number /Attach copy of admission letter as applicable		Have you undergone medical examination/fitness test? If Yes attach report	☐ YES ☐ NO

Detailed address of the Institution/Telephone No. & Name of the contact person at the institution:	If sponsored by persons / bodies other than above	Name of the Sponsor	Address	Phone No./ E-mail Id

Please Provide Details for	Course Duration	Date of commencement	Date of conclusion	Number of Semesters

Would like to state any thing that is not asked which you may want the insurer to know ?

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

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.