



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

PROPOSAL FORM for POS CHANNEL		Ref. 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.		
Unique Reference No.: SHAI/PR0036 and SHAI/PR0037		Policy No.					
Policy Issuing Office:		SM CODE			SM NAME		
		POS CODE			POS NAME		
POS	GST No.			PAN No.			
Name of the Proposer Mr / Mrs / Ms.				Date of Birth:			
Occupation of the Proposer				Annual Income Rs.:			
Residential Address:				Office Address:			
Pin Code:				Pin Code:			
Mobile Number		Email ID					
PAN Number		GST Number					
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: <input type="checkbox"/> a. Unorganized Sector <input type="checkbox"/> b. Economically Vulnerable or Backward Classes					Are you a ASHA workers		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> c. Other Categories of Persons <input type="checkbox"/> d. Informal Sector					Are you a MGNREGA workers		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>* "Social Sector" includes unorganised sector, informal sector, economically Vulnerable or backward classes and other categories of persons, both in rural and urban areas;</p> <p>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.</p> <p>b. "Economically Vulnerable or Backward Classes" means persons who live below the poverty line.</p> <p>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.</p> <p>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.</p>							
Policy Term (Please ✓)		<input type="checkbox"/> 1 Year / <input type="checkbox"/> 2 Years / <input type="checkbox"/> 3 Years		Period of Insurance		From	To
Pls check the brochure for policy term in respect of each product							
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)							
Do you want to pay the premium in Instalments: <input type="checkbox"/> YES <input type="checkbox"/> NO							
If yes choose Instalment options (Please Select the Option)				<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Halfyearly			
Premium can also be paid: Annually for 1 year term / Biennial for 2 year term / Triennial for 3 years							
Please check brochure for Instalment facility in each product							
Please Tick (✓) the Policy Opted		<input type="checkbox"/> FAMILY HEALTH OPTIMA INSURANCE PLAN UIN No.: SHAHLIP21211V042021			<input type="checkbox"/> MEDICLASSIC INSURANCE POLICY (INDIVIDUAL) UIN No.: SHAHLIP21215V052021		
Family Size (A=Adult, C=Child) (✓)		<input type="checkbox"/> 1A+1C	<input type="checkbox"/> 1A+2C	<input type="checkbox"/> 1A+3C	<input type="checkbox"/> 2A	<input type="checkbox"/> 2A+1C	<input type="checkbox"/> 2A+2C <input type="checkbox"/> 2A+1C
Sum Insured Opted for Family Health Optima Insurance Plan (Rs.)		<input type="checkbox"/> 4,00,000/-			<input type="checkbox"/> 5,00,000/-		
Sum Insured Opted for MediClassic Insurance Policy (Individual) Plan (Rs.)		<input type="checkbox"/> 1,00,000/-	<input type="checkbox"/> 2,00,000/-	<input type="checkbox"/> 3,00,000/-	<input type="checkbox"/> 4,00,000/-	<input type="checkbox"/> 5,00,000/-	
Sum insured Opted for Gold Plan MediClassic Insurance Policy (Individual) Plan (Rs.)		<input type="checkbox"/> 3,00,000/-		<input type="checkbox"/> 4,00,000/-		<input type="checkbox"/> 5,00,000/-	
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	Do you wish to receive the physical copy of the policy document	
				<input type="checkbox"/> YES	<input type="checkbox"/> 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				<input type="checkbox"/> KARVY <input type="checkbox"/> CAMSRep - CAMS Insurance Repository & Services <input type="checkbox"/> CIRL - Central Insurance Repository Limited <input type="checkbox"/> NDML - NSDL Data Management Services limited			
Bank Details of the Proposer	Account Number			Type of Account : <input type="checkbox"/> SB <input type="checkbox"/> CA <input type="checkbox"/> 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 : <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Voter ID <input type="checkbox"/> PAN Card <input type="checkbox"/> Driving License <input type="checkbox"/> Aadhar Card <input type="checkbox"/> 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)]		<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		
Sum Insured Opted (For Individual Policy) (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.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		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	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 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)					

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)

POS Code

POS Name

Signature of the POS

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 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:** _____

Proposal Form for POS Channel

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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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 _____ 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:

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.