



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

| | | | | |
|--|---|--|---|--|
| STAR CRITICAL ILLNESS MULTIPAY INSURANCE POLICY | | 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 Identification No.: SHAHLIP22140V012122 Proposal Form - Unique Reference No.: SHAI/PR0064 | | Policy No. | | |
| 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. | |
| Residential Address: | | Office Address: | | |
| Pin Code: | | Pin Code: | | |
| Mobile Number | | Email ID | | |
| PAN Number | | GST Number | | |
| Do you have a CKYC number | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes Please mention the 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 <input type="checkbox"/> c. Other Categories of Persons <input type="checkbox"/> d. Informal Sector | | Are you a ASHA workers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | Are you a MGNREGA workers | <input type="checkbox"/> Yes <input type="checkbox"/> 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. | | | | |
| Policy Term (Please ✓) | <input type="checkbox"/> 1 Year / <input type="checkbox"/> 2 Years / <input type="checkbox"/> 3 Years | 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) | | | | |
| Do you want to pay the premium in Instalments | <input type="checkbox"/> YES <input type="checkbox"/> NO | 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 | |
| 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 | | | | |
| 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 Insurance Repository Limited <input type="checkbox"/> CDSL Insurance Repository Limited | <input type="checkbox"/> CAMS Insurance Repository Services Limited <input type="checkbox"/> NSDL National Insurance Repository (NIR) | |
| 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 | Premium Amount | Rs. | Mode of Payment : Cash / Cheque / 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.) | | | | | | | | | | | |
| Sum Insured Opted (Rs.) <small>Note: Policy can be issued only if earning member is also covered. For non-earning member maximum sum insured is Rs.15,00,000/- Sum insured for the non-earning member should not exceed the sum insured of the earning member</small> | | | | | | | | | | | | |
| 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 | | | | | | | | | | | |
| Health History :Please provide answer in detail. A mere dash is not sufficient. | | | Family Physician's Name: _____ Phone: _____ Regn No: _____ | | | | | | | | | |

1. Has the person proposed for insurance ever suffered or suffering from any of the following

| | | | | | |
|--|--|--|--|--|--|
| a) Diabetes/high blood sugar/sugar in urine, High blood pressure/hypertension, Thyroid disorder? | | | | | |
| b) Heart and Circulatory Conditions/Disorders: chest pain, angina, high cholesterol/lipids, palpitations, congestive heart failure, coronary heart disease, heart attack, bypass surgery/angioplasty, valve disorder/replacement, pacemaker insertion, rheumatic fever, congenital heart condition, conduction abnormalities, varicose venis, thrombosis, blood disorders etc. | | | | | |
| c) Brain/Nervous System/Psychiatric Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, head injury, stroke, migraine headaches or chronic severe headaches, sleep apnea, multiple sclerosis, seizures/epilepsy or any other brain/nervous system Disease, Mental/Psychiatric disorder, disability or unable to perform day to day activities? | | | | | |
| d) Cancer/Tumor: Benign or Malignant tumor, Any growth/cyst, any cancer | | | | | |
| e) Respiratory Conditions/Disorders: Shortness/difficulty of breath, Tuberculosis, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease COPD, Chronic cough, coughing of blood, etc or any other lung/respiratory disorder/impairment of lung function | | | | | |
| f) Urinary Conditions/Disorders: Renal Failure/Chronic renal disorder, Renal Transplant, Congenital disorders of renal system, End Stage Renal Disorder, Proteinuria | | | | | |

| | | | | | |
|---|---|--|--|---|--|
| g) Digestive Conditions/Disorders: Jaundice, chronic diarrhea, intestinal bleeding/problems/polyps, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, inflammatory Bowel Disease unexplained weight loss or gain, eating disorder or any other gastro intestinal condition | | | | | |
| h) Autoimmune Disease (Rheumatoid Arthritis/SLE/Ankylosing Spondylitis etc.) or Genetic Disorder | | | | | |
| 2. 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 | | | | |
| 3. Has any application for insurance on proposed life been postponed, declined, rejected, accepted with special terms or accepted with extra premium? | | | | | |
| 4. Please provide details, if any, regarding occupation or business, which may render you to susceptible to injury or illness. (e.g. exposure to chemical substance/hazardous material/harmful dust or gases/explosives/working at heights/handling heavy machinery etc.)? or Does the person proposed for insurance take part in any hobbies/activities that could be considered dangerous in any way? E.g. aviation (other than as a farepaying passenger), mountainterring, deep sea diving or any form of racing? | | | | | |
| 5. Is the person proposed for insurance undergone or recommended to undergo any hospitalization, operation/sugery or any other investigations (excluding check ups for employment/insurance/foreign visit)? | | | | | |
| 6. Has the person proposed for insurance ever been tested positive for HIV/AIDS or been tested/treated for other sexually transmitted disease or awaiting the results of such a test? | | | | | |
| 7. Are any of your family members suffering from/have suffered from/have died of Heart Disease or High Blood Pressure or Stroke or Diabetes or Kidney disease or Cancer or HIV/AIDS? | | | | | |
| Additional Questions for female life- | | | | | |
| 1. Is the person proposed for insurance presently pregnant? if yes, please mention the expected date of delivery? | | | | | |
| 2. Any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy? | | | | | |
| 3. Has the person proposed for insurance ever undergone hysterectomy or ever had any disease of uterus, cervix or ovaries? | | | | | |
| 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

Received the proposal for **STAR CRITICAL ILLNESS MULTIPAY INSURANCE POLICY** 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:** _____

Star Critical Illness Multipay 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 NCPDR.

Submitted the above proposal for **STAR CRITICAL ILLNESS MULTIPAY INSURANCE POLICY** 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.

- 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.
- 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.