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

Unique Reference No.: SHAI/PR0002

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 CODE		AGENT NAME	
	SPECIFIED PERSON CODE		SPECIFIED PERSON NAME	

BUSINESS TYPE

Social Sector Classification* : ☐ Yes ☐ No

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

Rural Sector Classification : ☐ Urban ☐ Rural
This classification is based upon the address of the proposer

* "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;

Name of the Proposer Mr / Mrs / Ms.		**Date of Birth :**	
Occupation of the Proposer		**Annual Income Rs.:**	
Residence Address		**Pin Code :**	
Office Address		**Pin Code :**	
Email ID :		**Mobile Number**	
Aadhar (UID) Number		**Period of Insurance**	**To**
GST Number		**PAN Number**	

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, kindly provide e-Insurance Account (eIA) number _____

If no, choose any one Insurance Repository:

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

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

(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 Insurance Plan UID No.: IRDAI/HLT/SHAI/P-H/V.III/129/2017-18		**Star Family Delite Insurance Policy** UID No.: IRDA/NL-HLT/SHAI/P-H/V.I/139/13-14	
Mediclassic Insurance Policy (Individual) UID No.: IRDA/NL-HLT/SHAI/P-H/V.II/400/13-14		**Star Health Gain Insurance Policy** UID No.: SHAHLIP18088V021718	
Star Criticare Plus Insurance Policy UID No.: IRDA/NL-HLT/SHAI/P-H(C)/V.I/138/13-14			

Sum Insured Options Available * (✓)			
Sum Insured (Rs.)		Sum Insured (Rs.)	
1,00,000/-		5,00,000/-	
1,50,000/-		10,00,000/-	
2,00,000/-		15,00,000/-	
3,00,000/-		20,00,000/-	
4,00,000/-		25,00,000/-	

Please (✓) Family Size			
Family Size	Option	Family Size	Option
1A		2A	
1A+1C		2A+1C	
1A+2C		2A+2C	
1A+3C		2A+3C	
A=Adult		C= Child	

Add-on covers available under Mediclassic Insurance Policy (Individual)

1. Hospital cash ❑ 2. Patient care ❑

* please check brochure for the available sum insured option in respect of each product

Family Physician's Name _____

Phone_____ Regn No_____

Payments Details			
Annual Premium Rs.			❑ Cash / ❑ Cheque / ❑ DD
Cheque No. :	Date :	Drawn on :	Branch :

Bank Details of the proposer	Account Number :
	Type of Account : ❑ Savings ❑ Current ❑ 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.	

Please attach any of the following 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					
Height (cms)					
Weight (kgs)					
Relationship with proposer					
Occupation					
Annual Income (Rs.)					
Sum Insured Opted (Rs.)					
Applicable for Mediclassic Insurance Policy (Individual) - Do you want add on covers - If Yes, Please specify					

Signature / Thumb impression of the proposer :

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 advance premium receipt. If the proposal is accepted, the cover will commence from the date of the advance premium 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.

Signature of the authorised person

Date : **Place :** **Name & Code of the authorised person :**

Proposal Form No. : :

Insurance Coverage with this company and any other company - give details	Insured Person - 1	Insured Person - 2	Insured Person - 3	Insured Person - 4	Insured Person - 5
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					
2. Claim Amount Paid / Rejected					
3. Year of Claim					
Health History : Please provide answer in detail. A mere dash is not sufficient.					
1. Is the person proposed for insurance in good health and 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.					

Signature / Thumb impression of the proposer :

4.Has the person proposed for insurance ever suffered or suffering from any of the following	Insured Person - 1	Insured Person - 2	Insured Person - 3	Insured Person - 4	Insured Person - 5
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)					

Signature / Thumb impression of the proposer :

5. Has the person/s proposed for insurance		Insured Person - 1	Insured Person - 2	Insured Person - 3	Insured Person - 4	Insured Person - 5
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)						

Signature / Thumb impression of the proposer :

Please affix photograph of Insured Person - 1

Name : _____

_____

Please affix photograph of Insured Person - 2

Name : _____

_____

Please affix photograph of Insured Person - 3

Name : _____

_____

Please affix photograph of Insured Person - 4

Name : _____

_____

Please affix photograph of Insured Person - 5

Name : _____

_____

STAR Personal & Caring | Health Insurance

The Health Insurance Specialist

Declaration of the Intermediary : I / We confirm that the product has been explained to the proposer and is suitable for the proposer

Code : **Name :** **Signature of the Intermediary**

Declaration

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. 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.

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. I declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

I authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting 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.

In case of single Adult being covered along with children/child: I hereby confirm and warrant that I am single parent of the Child/Children proposed

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 Proposal Form is not filled by the proposer

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 connected documents 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.

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