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

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 CODE		AGENT MAME	
	BROKER CODE		BROKER MAME	

SPECIFIED PERSON CODE :	SPECIFIED PERSON NAME :

BUSINESS TYPE

Social Sector Classification* : ☐ Yes ☐ No

If Yes : ☐ a. Unorganised Sector ☐ c. Other Categories of Persons
☐ b. Economically Vulnerable or Backward Classes ☐ 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.				☐ Male	☐ Female
Occupation of the Proposer		**D.O.B.**		**Mobile No. while India**	
Name of the Insured Mr / Mrs / Ms.				☐ Male	☐ Female
Occupation of the Insured		**Mobile Number / Any other while Overseas**		**Relationship to the Proposer**	
Passport No		**Expiry Date**	**D.O.B.**	**Height & Weight**	
Local Address					
				Pin Code :	
Overseas Address					
Email ID				**Zip Code :**	
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 (e-IA) number, kindly provide e-Insurance Account (e-IA) number _____

If no, choose any one Insurance Repository:
(Kindly complete the enclosed EIA form)

☐ 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)

PLAN TYPE (TICK YOUR OPTION)

STAR TRAVEL PROTECT INSURANCE POLICY UID No.: IRDA/NL-HLT/SHAI/P-T/V.I/140/13-14			
INCLUDING USA AND CANADA		EXCLUDING USA AND CANADA	
PLAN A1 : USD 50000		PLAN A2 : USD 50000	
PLAN B1 : USD 100000		PLAN B2 : USD 100000	
PLAN C1 : USD 250000		PLAN C2 : USD 250000	
PLAN D1 : USD 500000		PLAN D2 : USD 500000	

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	
CTP 1 : USD 100000		STP 1 : USD 50000	
CTP 2 : USD 250000		STP 2 : USD 100000	
CTP 3 : USD 500000		STP 3 : 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 Y N

2) Countries to be visited : 1. _____ 2. _____

3. _____ 4. _____

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 _____

PAYMENT / INSURANCE DETAILS

Payment Mode : Cash / Cheque / DD / Credit Card

Cheque No _____ Date _____ Drawn on _____ Rs. _____

DD No _____ Date _____ Rs. _____ Drawn on _____ Payable _____

Credit Card No. _____ Exp Date. _____

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

Name : _____ Regn. No. & Qualification : _____

Address : _____

_____

Telephone No: _____ E-mail ID : _____

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

II 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?	
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	

III 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

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

Name of the Student	
Date of birth	
Name of the Institution where the student proposed to study	
I-20 Number /Attach copy of admission letter as applicable	
Detailed address of the Institution/Telephone No. & name of the contact person at the institution	
Please give : Course Duration	
Date of commencement	
Date of conclusion	
Number of Semesters	
Tuition fees per Semester : (Please give the detailed breakup)	
Tuitions financed by : Self / parents / borrowing from bank or FI's / please give details	Y N
Internship Period	
If sponsored by persons/bodies other than above	
a) Name of the Sponsor	
b) Address	
c) Phone No./ E-mail Id	Y N
Have you undergone medical examination/fitness test? If Yes attach report	
Would like to state any thing that is not asked which you may want the insurer to know ?	

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.

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 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.

Date : **Place :** **Signature of the authorised person**

Name & Code of the authorised person :

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.

Submitted the above proposal for **STAR** _____ **INSURANCE POLICY** along with payment ofRs._____/ 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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