CignaTTK Health Insurance Company Limited
Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063. IRDA Registration No. 151.
Call (Toll Free): 1-800-10-24462
Visit: www.cignattkinsurance.in **E-mail:** customercare@cignattk.in

Proposal Form No.: _____

FOR OFFICE USE

Branch Name*: _____ Branch Code: _____

Intermediary Name: _____ Intermediary Code*: _____

CIGNA TTK PROHEALTH INSURANCE POLICY

1 Please fill the form in BLOCK LETTERS. 2 All details marked with* are mandatory. 3 The Proposer must authenticate the cancellations / alterations in this form.

The Company's issuance of this form does not amount to acceptance of proposal. The actual liability of the Company does not commence until this proposal has been accepted by the Company and premium realised.

1. PROPOSER DETAILS:

Title* : Mr. ☐ Mrs. ☐ Ms. ☐ Gender*: Male ☐ Female ☐

Date of Birth* : D D M M Y Y Y Y Marital Status*: Married ☐ Single ☐ Others ☐

Name* : First* Middle Last*

Correspondence Address*:

Landmark:

City*: Town (District):

State*: Pin Code*:

Permanent Address* :
If same as above, please tick here ☐

Landmark:

City*: Town (District):

State*: Pin Code*:

E-mail : Address 1 Address 2

Telephone Number(s)* (Any one): Residence (Optional): Office (Optional):

Mobile*:

Occupation* : ☐ Government Employed ☐ Private Service ☐ Self Employed ☐ Housewife ☐ Student ☐ Retired ☐ Others

Annual Income : ☐ Up to 5L ☐ 5 - 10L ☐ 10 - 15L ☐ 15 - 20L ☐ above 20L

Educational Qualification: ☐ Less than class X ☐ Class X ☐ Class XII ☐ Graduate ☐ Post Graduate ☐ Professional Degree

Nationality*: Pan Card Number: (Mandatory for premium of ₹50,000 & above accepted in Cash)

2. POLICY/PLAN DETAILS:

Plan Type*:	Tenure*	Sum Insured*	Optional Deductible		Policy Period From
Individual ☐	1 Year ☐	**Cigna TTK ProHealth Protect**			D D M M Y Y Y Y
Floater ☐	2 Year ☐	2.5 Lacs ☐	Not Available		at : Hrs
		3.5 Lacs ☐	1 Lac ☐		
		4.5 Lacs ☐	1 Lac ☐	2 Lacs ☐	
		Cigna TTK ProHealth Plus			
Floater Type (if opted)		4.5 Lacs ☐	1 Lac ☐	2 Lacs ☐	
Adult (Max. 2) ☐		5.5 Lacs ☐	2 Lacs ☐	3 Lacs ☐	
Child (Max. 3) ☐		7.5 Lacs ☐	2 Lacs ☐	3 Lacs ☐	
		10 Lacs ☐	3 Lacs ☐		
		Cigna TTK ProHealth Preferred			
Portability		15 Lacs ☐			
Yes ☐		30 Lacs ☐	N.A.		
No ☐		50 Lacs ☐			
		Cigna TTK ProHealth Premier			
		1 Crore ☐	N.A.		

Please note that your Policy period will start from Premium Received Date at our Branch office in case of Cash payments or / as per Instrument date when paying through Cheque / Demand Draft / Pay Order. In case of Credit Card / Debit Card transactions, Policy period will start from date of debit of requisite premium from the Proposer's card / Bank account. This is applicable only where medical examination or underwriting is not required. In case a medical examination is to be done or an underwriting approval is required, the Policy shall commence on or after the date of approval by underwriter or the date of receipt of any additional premium, whichever is later.

Optional Covers Note: Voluntary Co-pay and Deductible cannot be opted in the same plan	**Reduction in Maternity Waiting Period** ☐	**Voluntary Co-pay** Co-pay 10% ☐ Co-pay 20% ☐
Add-on Cover Critical Illness ☐		

Zone of Cover (Please tick against your Zone):

Zone I (All India Cover) ☐ **Zone II (All India Cover excluding cities in Zone I)** ☐ **Zone III (Rest of India excluding cities in Zone I & II)** ☐

Your default zone is based on the city mentioned in your correspondence address. You have an option of upgrading to a higher zone which will enable you to get wider hospital network access outside your zone. If you choose to upgrade your Zone, please tick against the Zone of Cover you would like to opt.

Note : Zone can only be upgraded to higher than default. For complete details on classification of zone and applicable conditions please refer to the product brochure.

Cigna TTK ProHealth Insurance UIN Number: IRDA/NL-HLT/CTTK/P-H/V-I/390/13-14 • Version 1.4/Dec 2014

3. INSURED DETAILS:

Sr No.	Name (First*, Middle, Last*)	Gender*	DOB* (DD/MM/YYYY)	Relationship with Proposer*	Height* (Cms)	Weight* (Kgs)	Occupation*	City*	Sum Insured* (only for individual cover)
1									
2									
3									
4									
5									

4. NOMINEE DETAILS:

Nominee Name:

Relationship With Proposer:

In the event of death of the proposer, any payment due under the policy shall become payable to the nominee and the receipt of the proceeds by such nominee would be sufficient discharge to the Company. For all other persons covered under the policy, the proposer will be the nominee.

5. MEDICAL AND LIFESTYLE INFORMATION*:

Please answer the below mentioned questions in Yes (Y) / No (N). If the answer to any of the questions is Yes, please provide complete details in the table for additional medical information.

		Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
1	Do you or any of the persons proposed for Insurance Chew Tobacco / Smoke **YES** ☐ **NO** ☐ (If Yes, please ✓ against the relevant insured person)	☐	☐	☐	☐	☐
2	Have you or any of the persons proposed for insurance, ever suffered from or taken treatment, or hospitalised for or have been recommended to take investigations / medication / surgery or undergone a surgery for the following medical conditions? (If Yes, please ✓ against the applicable medical condition for relevant insured person) **YES** ☐ **NO** ☐					
	a) High or Low Blood Pressure / Chest Pain / Heart Disease	☐	☐	☐	☐	☐
	b) Diabetes or Pre-diabetes condition	☐	☐	☐	☐	☐
	c) Arthritis / Gout, Spondylitis, Joint Pain, Slip Disc, Spinal Disorder, Chronic Backache or any other disorder of the muscle / bone / joint	☐	☐	☐	☐	☐
	d) Tuberculosis, Asthma, Bronchitis or any other lung / respiratory or ENT disorder	☐	☐	☐	☐	☐
	e) Kidney Failure, Dialysis, Stones in kidney or urinary tract, Prostate disorder or any other kidney / urinary tract disorder or diseases of the reproductive organs	☐	☐	☐	☐	☐
	f) Liver Disease / Ulcers / Gall Bladder disorder or any other digestive tract or gastrointestinal disorder	☐	☐	☐	☐	☐
	g) Thyroid / Pituitary disorder or any other endocrine disorder	☐	☐	☐	☐	☐
	h) Cancer / Tumor (Swelling) - benign or malignant	☐	☐	☐	☐	☐
	i) HIV / AIDS / Sexually transmitted diseases	☐	☐	☐	☐	☐
	j) Anaemia or any other blood disorder	☐	☐	☐	☐	☐
	k) Stroke, Epilepsy, Paralysis or other brain or nervous system disorder	☐	☐	☐	☐	☐
	l) Psychiatric, Mental Illness or disorder	☐	☐	☐	☐	☐
	m) (Females) Fibroid, Cyst / Fibroadenoma, Bleeding Disorder, Pelvic infection or any other Gynaecological / Breast Disorder	☐	☐	☐	☐	☐
	n) Treatment for Alcohol Abuse, narcotics, rehabilitation for overuse of drugs or detoxication therapy	☐	☐	☐	☐	☐
	o) Any external ulcer / growth / cyst / mass anywhere in the body	☐	☐	☐	☐	☐
	p) Any type of Skin Allergies or diseases of the eye	☐	☐	☐	☐	☐
	q) Any other illness / disease / injury in the past 48 months other than for childbirth, flu or for minor injuries that have completely healed	☐	☐	☐	☐	☐
3	Has any application for life or health ever been declined, postponed, loaded or been made subject to any special conditions by Cigna TTK or any insurance company? **YES** ☐ **NO** ☐ (If Yes, please ✓ against the relevant insured person)	☐	☐	☐	☐	☐
4	To be answered if Critical Illness (Add-on Cover) is opted Have you or any of the persons proposed for Insurance been diagnosed with or undergone surgery for any of the following Critical Illnesses, prior to proposing for this cover - Cancer, Heart Attack, Coronary Artery, Bypass Graft, Heart Valve Replacement / Repair, Coma, Kidney Failure, Stroke, any Transplant, Paralysis, Multiple Sclerosis, Motor Neurone Disease **YES** ☐ **NO** ☐ (If Yes, please ✓ against the relevant insured person)	☐	☐	☐	☐	☐

6. ADDITIONAL MEDICAL INFORMATION:

If answers to any of the above questions is Yes, please elaborate below. Please attach extra sheets if required.

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Name of Insured					
Name of illness / injury suffering from or suffered in the past					
Date of first diagnosis (Month & Year)					
Treatment/medication received/receiving					
Whether fully cured					

Date: D D M M Y Y Y Y

Signature of Proposer*:

Cigna TTK ProHealth Insurance UIN Number: IRDA/NL-HLT/CTTK/P-H/V-I/390/13-14 • Version 1.4/Dec 2014

7. PREVIOUS / CURRENT INSURANCE DETAILS:

Please fill the following details with respect to health insurance policy(s) currently or held with Cigna TTK or any other insurance co. (Individual or Group)?

Insured	Policy No.	Insurer Name	From Date	To Date	Sum Insured	Claim Details			Cumulative Bonus Earned	
						Claim Number	Claimed Amount	Ailment	%	Amount
Insured 1										
Insured 2										
Insured 3										
Insured 4										
Insured 5										

For active policies, please attach policy copies.

8. PAYMENT DETAILS*:

Premium Amount: in Words:

Payment Option:

Cheque ☐ Demand Draft ☐ Pay Order ☐ Credit Card ☐ Debit Card ☐ Cash^ ☐

^For Cash Payments of Rs 50,000 and above, Pan Number is Mandatory.

a. For Cheque / DD / PO (Payable in favour of "CignaTTK Health Insurance Company Limited" - Proposal Form No.: _____)

Name of the Premium Payer:

Instrument Number: Instrument Date: Instrument Amount:

Bank Name:

b. For Credit / Debit Card:

Card No.: 16 digit Expiry Date: D D M M Y Y Y Y Card Type: Visa / Master / Amex:

Name on the Card:

*Payment to be collected only from Proposers Card / Bank Account

9. BANK ACCOUNT DETAILS*:

Mandatory details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account.

Please select any one of the below options as applicable.

☐ **Bank details as per premium cheque to be used for electronic fund transfer.**

Bank account details as mentioned on the cheque being submitted along with the Proposal Form towards premium payment for insurance Policy should be used by the Company for electronic fund transfer as mode of payment.

Please fill the below table if the premium payment cheque does not have all the details required for electronic fund transfer.

☐ **No existing Bank Account.**

I do not have any existing bank account. I agree to open a bank account and provide my bank account details to the Company for electronic fund transfer as mode of payment. I shall provide these details before renewal of my insurance policy or before any payment becomes due in relation to my insurance policy (whichever is earlier). I understand that as per regulatory requirement, Company shall process any payment in relation to my insurance policy only through electronic fund transfer after receipt of aforesaid pending bank details from me.

☐ **Cancelled Cheque submitted of Other Bank**

Bank account details (different from premium cheque) as provided below and for which I am submitting a cancelled cheque, should be used by the Company for electronic fund transfer as mode of payment. (Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly). I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy.

Particulars of Bank Account:

Account Number:

IFSC / MICR Code:

Name of the Bank:

Account Holder Name:

I agree and undertake to intimate in writing to CignaTTK Health Insurance Co. Ltd about any change in bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

Disclaimer: Cigna TTK shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation- failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/ incorrect information by Customer/Policy Holder.

Aforesaid NEFT transaction shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. Cigna TTK shall be indemnified against any loss/ damage/ claims caused to Cigna TTK in carrying out your aforesaid NEFT instructions.

Cigna TTK ProHealth Insurance UIN Number: IRDA/NL-HLT/CTTK/P-H/V-I/390/13-14 • Version 1.4/Dec 2014

Instructions:

- It is important for these electronic payment systems that the Policy Holder's name in the Policy must exactly match with the name in the Bank Account records/details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required.
- The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFS Code, which is applicable for NEFT only. (a number allotted to each participating banks branch) of the branch where the funds need to be transferred.
- Cancelled cheque should be attached along with the NEFT format.
- In case cancelled blank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required
- NEFT Form needs to be complete in all respect.

Date: D D M M Y Y Y Y **Signature:**

10. DECLARATION & AUTHORISATION*:

I / We 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 / We am / are authorised 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 / We further declare that I / We 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 / We 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 / We authorise 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 Government and / or Regulatory authority.

☐ I hereby confirm the receipt of Premium acknowledgment slip which is attached with this proposal form.

Date: D D M M Y Y Y Y **Place:** **Signature:**

11. VERNACULAR DECLARATION

I hereby declare that, I have fully explained the contents of the proposal form and Terms and Conditions of the policy to the Proposer in the language understood to him / her and that the Proposer has affixed the thumb impression above after fully understanding the contents thereof.

Date: D D M M Y Y Y Y **Place:** **Signature:**

12: INTERMEDIARY DECLARATION*:

I, (Full Name) in my capacity as an Insurance Advisor / Specified Person of the Corporate Agent / Authorised employee of the Broker / Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him / her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s) / information / response(s) is / are contained in this Proposal Form / including addendum(s), affidavits, statements, submissions, furnished / to be furnished, the Company shall have the right to vary the benefits which may be payable and furthermore, if there has been a non-disclosure of any material fact, the Policy issued to his / her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the Company.

License No. / ID (Advisor / Corporate Agent / Broker / Relationship Officer):

Date: D D M M Y Y Y Y **Place:** **Signature:**

SECTION 41 OF INSURANCE ACT, 1938 (PROHIBITION OF REBATES):

1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 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 prospectus or tables of the insurers.

2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

Business Type: Urban / Rural: Social / Non Social:

ACKNOWLEDGEMENT:

Received from Ms. / Mrs. / Mr:

a sum of Rs. through Cash# / Cheque / DD / Credit Card / Debit Card No. against your proposal for Cigna TTK ProHealth Policy.

Signature of Cigna TTK Official / Intermediary: Date: D D M M Y Y Y Y

Cigna TTK Official / Intermediary Name:

Time: Place:

Note: Neither the submission of a completed proposal for insurance or any payment for any policy sought oblige the Company to agree to issue a policy, which decision is and always shall be in the Company's sole and absolute discretion.

If Cigna TTK Health Insurance Company accepts a proposal for insurance, it shall be subject to the Board approved underwriting policy of CignaTTK Health Insurance Company Ltd. and the policy Terms and Conditions of Cigna TTK ProHealth Insurance Policy and the Company shall have no liability to make any payment if premium is not received by Cigna TTK Health Insurance Company in full and in time, or is not realised.

If a proposal is not accepted, Cigna TTK Health Insurance Company will inform you and refund any payment received from you without interest.

Insurance is a subject matter of solicitation

Cigna TTK ProHealth Insurance UIN Number: IRDA/NL-HLT/CTTK/P-H/V-I/390/13-14 • Version 1.4/Dec 2014