Proposal Form No.

Acknowledgment

Received the proposal for **Star Super Surplus (Floater) Insurance Policy** from Mr./Mrs/Ms._____ along with payment of Rs._____/- by Cash/Vide Cheque/DD No._____dated_____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 subject to realization of the cheque. If the proposal is not accepted, the amount paid will be refunded by our cheque.

Date:_____ Place:_____ Name & Code of the Authorised person _____ Signature of the Authorised person

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 understand that any wrong information provided can prejudice the claim and / or can result in cancellation of the policy

I also confirm that the source of funds for premium paid under this policy is legal.

The terminology in the proposal form with the terms and conditions of the product are explained to me

Place : _____

Date : _____ **Signature of the Proposer**

Prohibition of rebates : Section 41 of Insurance Act 1938 (Prohibition of rebates) : 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 rupee.

Received the acknowledgment for **Star Super Surplus (Floater) Insurance Policy** from Mr./ Mrs / Ms._____ along with payment of Rs._____/- by Cash /vide Cheque / DD No._____ dated._____ drawn on _____. The Cash/Cheque given is banked for operational convenience and banking of the cash / cheque does not mean acceptance of risk. The receipt of the cash / cheque will also be acknowledged by advance premium receipt in respect of proposer/s referred for medical examination. 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 by cheque.

Place : **Date:** **Signature of the Proposer**

PRO / SSF / V.1 / 2016 - 17

STAR Personal & Caring Health Insurance
The Health Insurance Specialist

SQPIL-23-03-16-59K-PO-150

Proposal Form No.

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

STAR Personal & Caring Health Insurance
The Health Insurance Specialist

Regd. & Corporate Office:
1, New Tank Street, Valluvar Kottam High Road,Nungambakkam,
Chennai - 600 034. Phone : 044 - 2828 8800. CIN : U66010TN2005PLC056649
Email : info@starhealth.in Website : www.starhealth.in IRDAI Regn. No: 129

PROPOSAL FORM FOR STAR SUPER SURPLUS (FLOATER) INSURANCE POLICY

Unique Identification No IRDAI/HLT/SHAI/P-H/V.II/164/2016-17

The company will not be on risk until the proposal has been accepted and full payment of premium has been made.

Please fill up the form in block letters. Also submit photographs of each of the person proposed for insurance for issuance of identity card.

POLICY ISSUING OFFICE:-	SALES MANAGER	MT/AGENT:
	SM CODE	MT/AGENT CODE:
	BRANCH CODE	

BUSINESS TYPE

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

Social Sector Classification* : ☐ Yes ☐ No

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

* "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. / Dr.

Address : _____

_____

Mobile No : _____ **Email Id :** _____

Occupation of the Proposer :

Period of Insurance : From : **To:** **PLAN OPTION: SILVER / GOLD (TICK)**

ID PROOF	PAN CARD No.	
	UNID NO :	
BANK DETAILS	Account Number	
	Bank Name and Branch	
	IFSC Code	

Affix Photographs	Affix Photographs	Affix Photographs	Affix Photographs

SUM INSURED OPTIONS FOR GOLD PLAN (Please check the brochure for available of sum insured for each defined limit)								
Sum Insured Rs.	5,00,000/-	10,00,000/-	15,00,000/-	5,00,000/-	10,00,000/-	15,00,000/-	20,00,000/-	25,00,000/-
Defined Limit Rs. (Please Tick)	5,00,000/-			10,00,000/-				

SUM INSURED OPTIONS FOR SILVER PLAN (Please check the brochure for available of sum insured for each deductible)		
Sum Insured Rs.	10,00,000/-	
Deductible Rs (Please Tick)	3,00,000/-	5,00,000/-

Family Physician's Name _____

Phone _____

Regn No _____

INSURED PERSON DETAILS :-
(PLEASE FILL IN THE RESPECTIVE COLUMN FOR EACH OF THE PERSON PROPOSED TO BE COVERED):-

SL. NO.	NAME OF THE PERSON PROPOSED FOR INSURANCE	GENDER	DATE OF BIRTH	RELATIONSHIP WITH PROPOSER	OCCUPATION
1.					
2.					
3.					
4.					

INSURED PERSON DETAILS (PLEASE FILL IN THE RESPECTIVE COLUMN FOR EACH PERSON PROPOSED TO BE COVERED)	1	2	3	4
Name of the person proposed for Insurance				
Gender				
Date of Birth				
Height (cms)				
Weight (kgs)				
Annual Income				
Name of the Nominee				
Age and Date of Birth of the Nominee				
Relationship of the Nominee to the proposer				
% of the claim.				
Details of other previous Insurance ,if any				
1. Name of the Insurance Company				
2. Period of Insurance				
3. Sum Insured(Rs)				
4. Policy No.				
Details of other insurance / cover simultaneously available on indemnity basis, if any.				
Details of Claims				
1. Ailment for which Claim was made				
2. Claim Amount Paid/rejected				
3. Year of Claim				
Health History				
Please give answer in detail. A mere dash is not sufficient.				
1. Is the person proposed for Insurance in good health and free from physical and / or mental disease or infirmity, If not give details				
2. Has the person proposed for insurance consulted / taken treatment / been admitted for any illness / injury, If Yes, details				
3. Does the person proposed for insurance has any complications during / following birth. If yes, please submit all necessary documents.				
4. Has the person proposed for insurance 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				

INSURED PERSON DETAILS (PLEASE FILL IN THE RESPECTIVE COLUMN FOR EACH PERSON PROPOSED TO BE COVERED)	1	2	3	4
d) Stroke, epilepsy, fainting attack, chronic headache-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-If Yes since when				
i) Disease of Stomach, intestine, Liver, gall bladder / pancreas, Kidney, Urinary bladder, Urinary Tract Diseases-If Yes since when				
j) Disease of prostrate / fistula/piles/genital diseases - If Yes since when				
k) Cataract and other diseases of the eye and ENT disease-If Yes since when				
l) Any Other Problem (Please Specify)				
5. Have any of the persons proposed for insurance				
1. Undergone any medical test?				
2. Been prescribed any medicines.				
a) Name the illness for which medicines have been prescribed				
b) Details of medicines and drugs prescribed.				
c) Period for which these drugs were taken.				
3. Been advised for any surgery?-If Yes give details				
4. 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 CD4 count (pl attach proof)				