

Received the proposal for **STAR CARE INSURANCE POLICY** from Mr/Mrs/Ms. _____ drawn on _____ along with payment of Rs. _____ /- by Cash /
 vide Cheque/ DD No. _____ dt. _____. 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

Name & Code of the authorised person :

Place :

Date :

4. Have any of the persons proposed for insurance																				
1. Undergone any medical test?																				
2. Prescribed any medicines.																				
a) Name the illness for which medicines have been prescribed																				
b) Details of medicines and drugs prescribed.																				
c) Period for these drugs were taken.																				
3. Have been advised for any surgery?-If Yes give details																				
4. Received /receiving any payment for any disability / injury / illness / disease																				
5. 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																				
6. Are you positive for HIV, if yes please mention your Cd 4 count (pl attach proof)																				

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

Name : _____ **Code :** _____ **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. The terminology in the proposal form with the terms and conditions of the product are explained to me .

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 **STAR CARE INSURANCE 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 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.

For Office Use Only

Tick as applicable : Tier-1: _____ Tier-2: _____ Rural: _____



STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office : 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034. Phone : 044 - 2828 8800

CIN : U66010TN2005PLC056649 Email : support@starhealth.in Website : www.starhealth.in IRDAI Regn. No : 129

PROPOSAL FORM FOR STAR CARE INSURANCE POLICY

Unique Identification No. : IRDA/NL-HLT/SHA/P-HV.1/10/14-15

Ref. No.		Policy No.	
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The company will not be on risk until the proposal has been accepted and full payment of premium has been received

Policy Issuing Office

Sales Manager		MT/ Agent:	
SM Code:		MT / Agent Code:	

BUSINESS TYPE

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

Social Sector Classification* : Yes No

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;

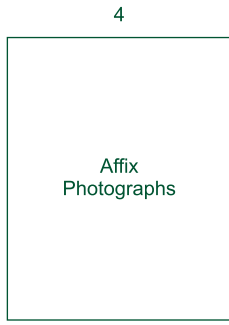
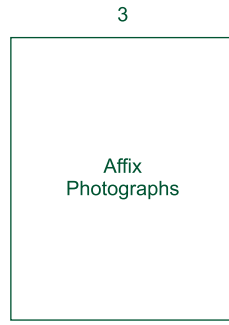
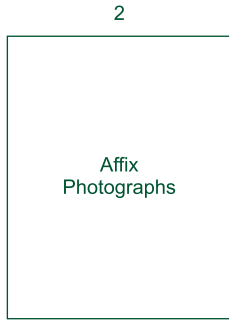
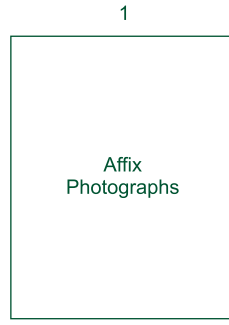
Name of the proposer	DOB :	
Address	Health Insurance	
Mobile	Email Id:	
Aadhar No. :	GST No. :	PAN No. :
Period of Insurance :	From :	To :
Bank Details of the proposer :	Account No :	Type of Account : <input type="checkbox"/> Savings <input type="checkbox"/> Current <input type="checkbox"/> Others please specify
	Bank Name & Branch :	IFSC Code :

Please attach a photo copy of cancelled cheque leaf of the above Bank Account.

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

(In case of Multiple nominees a separate form containing nominee details should be enclosed duly specifying the % to each nominee)

Payment Details		
Cash	Cheque No.	Date
Drawn on	Branch	
Please attach any of the following 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 ID Card (UID) <input type="checkbox"/> Any other Govt. Recognised Proof		



Policy Type :	Individual / Floater (1A+1C,1A+2C,2A,2A+1C,2A+2C)
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Family Physician's Name:	
Phone:	
Regn No.:	

Insured person Details (Please fill in the respective column for each person proposed to be covered. Please do not leave any question unanswered. This may lead to denial of claim)				
	1	2	3	4
Name				
Date of Birth				
Gender				
Height (cm)				
Weight (kg)				
Eye Colour				
Distinguishing Marks				
Occupation				
Annual Income				
Sum Insured Rs.				
Details of other / previous Insurance ,if any				
1. Name of the Insurance Company				
2. Period of Insurance				
3 . Sum Insured(Rs)				
4. Policy Type				
Details of Claims if any				
1. Allment 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. Are you in good health and free from physical and mental disease or infirmity, if not give details				
2. Have you consulted / taken treatment/been admitted for any illness/injury, if Yes ,details				
3. Have you ever 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				
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 prostate / 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)				