Proposal Form No.:

**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._____. 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 collection receipt. If the proposal is accepted, the cover will commence from the policy start date as stated in the policy schedule, 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:**



**Super Star Proposal Form 1 (Floater)**

| Please affix stamp size photograph of Insured Person - 1 | Please affix stamp size photograph of Insured Person - 2 | Please affix stamp size photograph of Insured Person - 3 | Please affix stamp size photograph of Insured Person - 4 | Please affix stamp size photograph of Insured Person - 5 | Please affix stamp size photograph of Insured Person - 6 |
|---|---|---|---|---|---|

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.

**Declaration**

The primary duty of the proposer is to fill out the proposal form and also to make sure that the proposal contains all the details correctly. If you or any of the insured person(s) have suffered or suffering from any of the diseases which has not been mentioned in the proposal, the claim that may arise will result in a repudiation of the claim/cancellation of the policy.

I/we agree that the PAN details and other information provided by me/us in the proposal form may be used by the Company to download/ verify / modify / add my/our KYC documents from the CERSAI* CKYC portal for processing this application. I/We understand that only the acceptable officially valid documents would be relied upon for processing this application. (*Central Registry of Securitization and Asset Reconstruction and security Interest of India) I hereby consent to receiving information from Central KYC Registry through SMS / email on the above registered number/email address.

1. 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. 2. 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 insurer and that the policy will come into force only after full payment of the premium chargeable. 3. 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. 4. I declare that I consent to the company seeking medical information from any doctor or from a hospital who/which at anytime has attended on the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement. 5. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and /or claims settlement and with any Governmental and/or Regulatory authority, which includes sharing of my medical data through ABHA. 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. I hereby confirm that the features of the product have been understood by me. I hereby authorize Star Health and Allied Insurance Company to contact me. It will override my registry on the NCPR.

I would like to contribute in creating a healthier, greener and cleaner environment by receiving my Insurance Policy documents and service related communications only via electronic mode.

| Place | Date | Name | Signature / Thumb impression of the proposer |
|---|---|---|---|
| | | | |

**Signature / Thumb impression of the proposer:**

**Prohibition of Rebates: Section 41 of Insurance Act 1938.**

1. 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.
2. 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.

**WHERE THE PROPOSER IS ILLITERATE OR SIGNS IN A LANGUAGE DIFFERENT FROM THAT OF THE LANGUAGE OF THE PROPOSAL FORM.**

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 features of the product have been fully explained to me and I have fully understood the significance of the proposed contract.**

| Signature / Thumb impression of the proposer |
|---|
| |

Beware of spurious phone calls and fictitious/fraudulent offers and never respond to calls/emails/embedded links in SMS/emails asking you to update User id/Password/Credit Card Number/CVV/OTP etc. Insurance is a contract of the utmost good faith, requiring the insured to answer all of the questions on the proposal form honestly and without omitting any information that is relevant. When submitting the proposal form, kindly reveal all pertinent information. If any important information is omitted from the proposal form, personal statement, declaration, or related papers, or if the proposer or someone acting on his behalf makes any false or erroneous statements, misrepresentations, or omissions, the Policy will be invalid, at the insurer's discretion. Please get in touch with the company's offices or agents if you have any questions about the proposal form.

PRO SS/FLN.1/2024

Proposal Form No.:

**Super Star Proposal Form (Floater) - Unique Reference No.: SHAI/PR0082** **Pro/SS FL / V.1 /2024** 

STAR Personal & Caring Health Insurance — The Health Insurance Specialist

Ref. No.: _____

Policy No.: _____

**PLEASE FILL UP THE FORM IN BLOCK LETTERS**

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

| Policy Issuing Office | SM CODE | |
|---|---|---|
| | SM NAME | |
| | AGENT / CORPORATE AGENT / BROKER / IMF / POSP / CODE | |
| | AGENT / CORPORATE AGENT / BROKER / IMF / POSP / NAME | |

Please affix Passport size photograph of the Proposer

**POSP PAN NUMBER** **POSP GST NUMBER**

## PROPOSER DETAILS

| | Prefix | First Name | Middle Name | Last Name |
|---|---|---|---|---|
| Proposer Name (same as KYC/ID proof) | | | | |
| Father / Spouse Name | | | | |
| Mother Name | | | | |

**Date of Birth** (D D M M Y Y Y Y) **Gender** Male ☐ Female ☐ Transgender ☐ **Occupation**

**Business Type**

Do you come under below mentioned Social Sector Classification* ☐ Yes ☐ No

If Yes (please tick) ☐ Unorganized Sector ☐ Economically Vulnerable or Backward Classes ☐ Other Categories of Persons ☐ Informal Sector

**Rural and Social Sector Classification**

Are you a ASHA worker ☐ Yes ☐ No

Are you a MGNREGA worker ☐ Yes ☐ No

* "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.

**Source of Income** ☐ Salaried ☐ Business ☐ Others, please specify _____ **Proof of Income to be submitted** ☐ IT Returns ☐ 3mths Payslip ☐ Other Proof, please specify _____

**Annual Income (in Rs.) :** **PAN Number†** **If PAN number is not available submit Form 60†** ☐

**GST Number** **Residential Status** ☐ Indian Resident ☐ NRI ☐ PIO ☐ Foreign National

**CKYC Number** **Email ID**

**Do you wish to update CKYC with the KYC details provided here** ☐ Yes ☐ No **Are you (Proposer) or any of the insured person is a PEP (Politically Exposed Person) or related to PEP††** ☐ Yes ☐ No **If yes, please provide details** _____

| | | Current Address | Permanent Address (should be same as address Proof) |
|---|---|---|---|
| Address line 1 | | | |
| Address line 2 | | | |
| City / Town / Village | | | |
| District | | | |
| State | | | |
| Country and Pincode | | | |
| Mobile Number / Alternate Mobile Number | | | |

**Please attach any one proof in support of ID and Address††** ☐ Voter ID ☐ Driving License Exp Dt.: ☐ Aadhar Card ☐ Passport Exp Dt.: ☐ NREGA Job Card ☐ Any Other Govt. Notified Document

**Nomination.** It is Mandatory to fill Annexure to Proposal Form (Nomination Form)

Nominee's Name : Relationship to Proposer : Date of Birth (D D M M Y Y Y Y) Age ☐ in yrs

Name of the Appointee (if nominee is a minor) : Relationship to Nominee : Date of Birth (D D M M Y Y Y Y) Age ☐ in yrs

(Incase of Multiple nominees a separate form containing nominee details should be enclosed duly specifying the % to each nominee) **Do you wish to receive the physical copy of the policy document** ☐ Yes ☐ No

**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, please provide:**

**If you don't have an (eIA) number, please choose any one Insurance Repository**

☐ Karvy Insurance Repository Limited ☐ CAMS Insurance Repository Services Limited

☐ CDSL Insurance Repository Limited ☐ NSDL National Insurance Repository (NIR)

**Please choose the Policy Term** ☐ 1yr ☐ 2yr ☐ 3yr ☐ 4yr ☐ 5yr **Period of Insurance** From (D D M M Y Y Y Y) To (D D M M Y Y Y Y)

Premium can also be paid: Annually for 1 year term / Biennial for 2 year term / Triennial for 3 years

**Do you want to pay the premium in Instalments** ☐ Yes ☐ No **If yes (Please choose Instalment option)** ☐ Monthly ☐ Quarterly ☐ Halfyearly

(Please check the brochure for policy term and Instalment facility in respect of each product)

†The copy of PAN card or Form 60 is mandatory | ††If CKYC number is provided, proof of submission is not mandatory | †††Politically Exposed Persons (PEPs) are individuals who are or have been entrusted with prominent public functions in a foreign country, example, Heads of State or of Governments, senior politicians, senior government / judicial / military officials, senior executives of state owned corporations, important political party officials, etc., including their family members and close relatives.

## Super Star (UIN-SHAHLIP25036V012425)

**Family Size A=Adult, C=Child**: 1A | 1A+1C | 1A+2C | 1A+3C | 1A+4C+ ; 2A | 2A+1C | 2A+2C | 2A+3C | 2A+4C+

**Mode of Payment**: Cheque | DD | Debit Card | Credit Card | NEFT | ECS | CC Mandate | Cash *(Cash payments are not eligible for the 80D tax benefits)*

**Premium Amount** Rs.

**Sum Insured on Floater Basis (Rs)**

5,00,000 | 7,50,000 | 10,00,000
15,00,000 | 20,00,000 | 50,00,000
100,00,000 | Unlimited Sum Insured

**Bank Details of the Proposer**

Account Number _____

Type of Account: Savings Account | Current Account | Others Please Specify _____

Name of the Bank : _____
Name of the Branch : _____
IFSC Code : _____

**Payment Details** (Please attach a photo copy of cancelled cheque leaf).

Cheque / DD No. :
Date : D D M M Y Y Y Y
Branch :

| Details of the person/s proposed for Insurance | | Insured Person - 1 | | Insured Person - 2 | | Insured Person - 3 | | Insured Person - 4 | | Insured Person - 5 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | | | | | | | | | | | |
| Gender | Date of Birth | M / F / Transgender | DD/MM/YYYY | M / F / Transgender | DD/MM/YYYY | M / F / Transgender | DD/MM/YYYY | M / F / Transgender | DD/MM/YYYY | M / F / Transgender | DD/MM/YYYY |
| Height (cms) | Weight (kgs) | CMS | KGS | CMS | KGS | CMS | KGS | CMS | KGS | CMS | KGS |
| Relationship with proposer | | | | | | | | | | | |
| Occupation | Annual Income (Rs.) | | | | | | | | | | |
| Ayushman Bharat Health Account (ABHA) No. | | | | | | | | | | | |
| Sum Insured Opted (For Individual Policy) (Rs.) | | | | | | | | | | | |
| Existing Insurance Coverage with us and/or any other company give details | 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 / Year | | YYYY | | YYYY | | YYYY | | YYYY | | YYYY |
| | 2. Claim Amount Paid / Rejected | | | | | | | | | | |
| Have you ever been declined health insurance coverage due to a diagnosis of a health condition? | | | | | | | | | | | |

**Health History: Please provide detailed, response-specific diagnosis and treatment. A mere dash is not sufficient**

Family Physician's Name: _____ Phone: _____ Regn No: _____

**Note : If any of the below mentioned questions from "1 to 9" is "YES" and if additional space is needed to provide medical condition in detail, please enclose a seperate sheet along with this proposal form.**

| | Insured Person - 1 | Insured Person - 2 | Insured Person - 3 | Insured Person - 4 | Insured Person - 5 |
|---|---|---|---|---|---|
| 1. Is the person proposed for insurance in good health 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. | | | | | |
| 4. Whether the insured person is pregnant if yes, kindly provide duration of pregnancy and scan reports | | | | | |
| **5. Has the person proposed for insurance ever suffered or suffering from any of the following** | | | | | |
| a) Diabetes Mellitus –if yes, mention the duration/date of diagnosis, Type and medication details. | | | | | |
| b) High BP/ Cholesterol – if yes, mention duration/date of diagnosis and medication details | | | | | |
| c) Thyroid disorders, specify diagnosis Hypo / Hyperthyroid / Autoimmune thyroiditis, Goitre etc), duration/date of diagnosis and medication details | | | | | |
| d) Heart and vascular disease / Arrhythmias / valvular diseases / Cardiomyopathy – if yes, mention duration/date of diagnosis, medication details, Intervention done, CAG, PTCA, CABG and others) | | | | | |
| e) Stroke, epilepsy, fainting attack, chronic headache, Parkinson's disease, Alzheimer's disease, mental disease or infirmity? – if yes, mention the duration/date of diagnosis and medication details | | | | | |
| f) Tuberculosis, asthma, COPD, ILD, other respiratory diseases if yes, mention – duration/date of diagnosis and medication details | | | | | |
| g) Disease of bones/joints, slipped disc, spinal disorder, injury to ligaments – if yes, mention duration/date of diagnosis and operation or treatment details | | | | | |
| h) Whether diagnosed to have arthritis (Rheumatoid / Osteo arthritis or any other inflammatory arthritis like Ankylosing spondylitis). If yes, mention treatment details and submit all records | | | | | |
| i) Gynecological disorder such as menstrual irregularity (DUB), fibroid uterus, ovarian cyst- or have undergone cesarean / hysterectomy – if yes, mention duration/date of diagnosis and medication details | | | | | |
| j) Treatment for sub-fertility or has been advised for? (answer if applicable – if yes, mention duration/date of diagnosis and medication details | | | | | |
| k) Disease of stomach, intestine, liver, gall bladder / Pancreas, Piles / Fistula / Fissure / Hernia if yes, mention duration/date of diagnosis and medication details | | | | | |
| l) Disease of kidney, urinary bladder, urinary tract disease, Calculi- if yes, duration/date of diagnosis and medication details | | | | | |
| m) Disease of prostate / hydrocele / genital disease / - if yes, mention duration/date of diagnosis and medication details | | | | | |
| n) Diseases of the eye, Cataract / corneal / retinal, other disorders and Ear, Nose Throat disease –if yes, mention duration/date of diagnosis and medication details | | | | | |
| o) Cancer, Precancerous lesions, Non-healing ulcers – if yes, mention type of cancer, duration/date of diagnosis and treatment details | | | | | |
| p) Any blood disorder, specify the diagnosis, mention duration/date of diagnosis and medication details | | | | | |
| q) Any autoimmune disease / any long-term steroid / Immunosuppressant intake like myasthenia gravis / SLE / Psoriasis, Ulcerative Colitis, Crohn's disease etc.) duration/date of diagnosis and medication details. | | | | | |
| r) Any other Health problems/diseases please specify | | | | | |
| **6. Has the person proposed for insurance** | | | | | |
| a) Undergone any medical test? | | | | | |
| b) Prescribed any medicines? If yes<br>1. Name the illness for which medicines have been prescribed | | | | | |
| 2. Details of medicines and drugs prescribed | | | | | |
| 3. 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 / diseases. Give details | | | | | |
| **7. Does the person proposed for insurance has any of the mentioned habits** | | | | | |
| a) Chew Tobacco - If yes, since when | | | | | |
| b) Smoke - If yes, since when | | | | | |
| c) Consume Alcohol - If yes, since when | | | | | |
| d) If a, b and c, are mentioned as yes, mandatory to give details whether diagnosed with any local or systemic disease / complications. | | | | | |
| 8. Is the person proposed for insurance positive for HIV, Hepatitis B/C If yes, mention duration/date of diagnosis, medication details, CD4 count (please attach proof) and Viral load | | | | | |
| 9. Type and the total number of medical documents provided | | | | | |

| Declaration of the Agent / Intermediary : I / We confirm that the product's suitability has been explained to the proposer. The information furnished in the proposal is true to the best of my knowledge and recommend acceptance of the proposal. (Please Enclose Insurance Agent's Confidential Report, If Any) | | | | |
|---|---|---|---|---|
| | Date | Code | Name of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF / POSP | Signature of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF / POSP |

**Super Star Proposal Form (Floater)** **Unique Identification No.: SHAHLIP25036V012425** **Proposal Form No. SHAI/PR0082**

## Name of optional cover - Status

| S.No. | Name of the optional cover | Insured Person 1 (Adult Male) | Insured Person 2 (Adult Female) | Insured Person 3 | Insured Person 4 | Insured Person 5 |
|---|---|---|---|---|---|---|
| 1 | Quick Shield | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2 | Personal Accident Cover (Option A - Accidental death cover/ Option B - Accidental death cover Permanenant total disability) | Option A ☐ Option B ☐ | Option A ☐ Option B ☐ | | | |
| 3 | Reduction of PED Waiting Period (from 36 months) | 36 to 24 months ☐ 36 to 12 months ☐ | 36 to 24 months ☐ 36 to 12 months ☐ | 36 to 24 months ☐ 36 to 12 months ☐ | 36 to 24 months ☐ 36 to 12 months ☐ | 36 to 24 months ☐ 36 to 12 months ☐ |

| | Name of the optional cover | | Status |
|---|---|---|---|
| 4 | Smart Network | | ☐ |
| 5 | Coverage for Non-Medical Items (Consumables cover Table I (68 items)) | | ☐ |
| 6 | Maternity Expenses | Delivery Expenses and New Born Cover | Option A - Rs. 1,00,000 ☐ Rs. 50,000 ☐ (Waiting Period: 24 months) Option B - Rs. 30,000 ☐ (Waiting Period: 12 months) |
| | | Assisted Reproduction Treatment | ☐ |
| 7 | Women Care | | ☐ |
| 8 | High-end Diagnostics | | ☐ |
| 9 | Annual Health Check-up | | ☐ |
| 10 | Voluntary Co-payment | | 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ |
| 11 | Voluntary Deductible | | Rs.10,000 ☐ Rs.25,000 ☐ Rs.50,000 ☐ Rs.1,00,000 ☐ Rs.2,00,000 ☐ Rs.3,00,000 ☐ Rs.4,00,000 ☐ Rs.5,00,000 ☐ |
| 12 | Room Rent Modification | | Single Private AC Room ☐ Shared Room ☐ General Ward ☐ |
| 13 | E- International Second Opinion | | ☐ |
| 14 | Durable Medical Equipment Cover | | ☐ |
| 15 | Compassionate Visit | | ☐ |
| 16 | Hospital Cash | | Rs.1,000 ☐ Rs.2,000 ☐ Rs.3,000 ☐ Rs.4,000 ☐ Rs.5,000 ☐ |
| 17 | Reduction of Specific Diseases Waiting Period 24 months to 12 months | | ☐ |
| 18 | Limitless Care | | ☐ |
| 19 | Super Star Bonus (Guaranteed Bonus) | | ☐ |
| 20 | NRI Advantage | | ☐ |

* Please refer and fill **Annexure to Proposal Form - Star Flexi** for more covers.