I hereby declare that I am not travelling against the advice of the Physician and will not be travelling for the purpose of obtaining medical treatment. I understand that this Policy does not cover any pre-existing medical condition/injury/illness/deformity and any complications arising therefrom whether declared or undeclared. I authorize STAR Health and Allied Insurance Co. Ltd. to seek any information relating to my physical and mental health and I authorize that Doctor to give such information to the STAR Health and Allied Insurance Co. Ltd. and to authorized claims Administrator of the STAR Health and Allied Insurance Co. Ltd.

I hereby declare and aver that the details furnished above are true and complete in all respects and all material information pertaining to me and medical history have been disclosed to you.

I agree to this proposal and this declaration shall be the basis for this contract between me and STAR Health and Allied Insurance Company Limited.

I agree that any misrepresentation of any material information given above would make this contract null and void.

Date :

Place : Signature of the Proposer

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	
Detailed address of the Institution/Telephone No.	
Number of Semesters	
Tution fees per Semester	
Tutions financed by (Self, parents, borrowing from bank or FI's) please give details	
If sponsored by persons/bodies other than above a) Name of the Sponsor b) Address c) Phone No./ E-Mail Id	
Have you undergone medical examination / fitness test ?	Y N
Would like to state any thing that is not asked which you may want the insurer to know ?	

Signature of the Proposer

Form No. STI06

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Corporate Office : 1, New Tank Street, Valluvarkottam High Road, Chennai - 600 034.

STAR TRAVEL PROTECT INSURANCE PROPOSAL

Producer Name

Producer Code

Issuing Office Address :

STAR TRAVEL PROTECT INSURANCE PROPOSAL

IMPORTANT

PLEASE MAKE SURE YOU READ AND FULLY UNDERSTAND THIS DOCUMENT BEFORE YOU TRAVEL FROM THE REPUBLIC OF INDIA.

THE PROPOSAL FORM SHOULD BE COMPLETED TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, AND ALL QUESTIONS SHOULD BE ANSWERED. FAILURE TO DO SO MAY NULLIFY COVER UNDER THE POLICY ISSUED.

PLAN TYPE

STAR TRAVEL PROTECT (INDIVIDUAL)

WORLDWIDE INCLUDING USA AND CANADA		WORLDWIDE EXCLUDING USA AND CANADA	
PLAN A1 : USD 50000	☐	PLAN A2 : USD 50000	☐
PLAN B 1 : USD 100000	☐	PLAN B2 : USD 100000	☐
PLAN C1 : USD 250000	☐	PLAN C2 : USD 250000	☐
PLAN D1 : USD 500000	☐	PLAN D2 : USD 500000	☐

STAR FAMILY TRAVEL PROTECT

WORLDWIDE INCLUDING USA		WORLDWIDE EXCLUDING USA		ASIA PLANEXCLUDING JAPAN & HONGKONG	
FLY A1 : USD 50000	☐	FLY A2 : USD 50000	☐	FLY A3 : USD 50000	☐
FLY B1 : USD 100000	☐	FLY B2 : USD 100000	☐	FLY B3 : USD 100000	☐
FLY C1 : USD 250000	☐	FLY C2 : USD 250000	☐	FLY C3 : USD 250000	☐

STAR CORPORATE TRAVEL PROTECT (Worldwide)		STUDENTS PLAN			
CTP 1 : USD 100000	☐	STP 1 : USD 50000	☐	TSF - 1 : USD 75000	☐
CTP 2 : USD 250000	☐	STP 2 : USD 100000	☐	TSF - 2 : USD 150000	☐
CTP 3 : USD 500000	☐			TSF - 3 : USD 250000	☐

IF THE PROPOSER IS ABOVE 70 YEARS OR PROPOSERS WITH ADVERSE MEDICAL HISTORY IRRESPECTIVE OF AGE, THE PROPOSAL FORM SHOULD BE ACCOMPANIED WITH :

1. ECG PRINTOUT WITH REPORT
2. FASTING AND POST PRANDIAL BLOOD SUGAR TEST REPORTS
3. URINE STRIP TEST REPORT
4. CHOLESTROL PROFILE

AND MEDICAL HISTORY HAS TO BE COMPLETED AND SIGNED BY AN MD WHO HAS SPECIALISED IN CARDIOLOGY

In the absence of medical tests and reports before travel, cover will be granted for US $ 10000 (US Dollars Ten Thousand only) for the emergency medical treatment of illness or disease. However in case of accident full Sum Insured benefit would be available.

TRAVEL DETAILS

i) Does your trip include USA & / or CANADA Y N

ii) Countries to be visited

1.

2.

3.

iii) How Frequently do you travel overseas ?

Departure from India: Date D D M M Y Y

Return to India : Date D D M M Y Y

No.of Days

Purpose of Visit : Business Holiday Study Others

Nature of Visa:

PAYMENT /INSURANCE DETAILS:

Payment Mode : Cheque No.

Cash

DD No.

Payable at

Date D D M M Y Y

Bank Name

Deposit Slip No.

Date D D M M Y Y

Insurance Plan Requested :

INSURED'S DETAILS :

Insured Name : Mr./Mrs.

Male/Female M F Date of Birth D D M M Y Y

Passport No. Expiry Date D D M M Y Y

Occupation

Residential Address

Telephone No.

E-mail ID

Mobile No. In India While Overseas :

ADDITIONAL INSURED FAMILY MEMBERS (Spouse or dependent children) (applicable only for Family Coverage)

Sl No.	Name	Sex M/F	Date of birth	Passport No.	Assignee Name	Relationship

(No refund of premium is permissable 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).

FAMILY PHYSICIAN DETAILS

Name

Regn. No. Qualification

Address

Telephone No :

E-mail ID :

II Medical History

Are you suffering or have you ever suffered from any illess/disease up to the time of making this proposal ?	
Do you have any physical defect or deformity ?	
Have you ever been hospitalized for treatment / observation? If so, please furnish details.	
Are you currently or in the past have been on Medication? Please furnish details.	
Have you suffered from any illness or had an Accident in the preceeding 12 months ?	

III Medical History of the proposer to be completed by M.D. Cardiologist (Applicable for persons with adverse medical history, irrespective of age, and persons over 70 years)

1. Medical History	
2. Any Past History of Disease, Operation	
3. How frequently the proposer would visit you for advice/treatment ?	
4. From the Lab reports - ECG, Fasting and Post Prandial Blood Sugar Test, Urine Strip Report and Cholestrol Profile, do you consider that the Proposer is fit to undertake Travel Abroad?	

Date :

Place :

Signature of the Doctor with Registration Number