STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034. ★ Phone : 044 - 28288800 ★ Email : support@starhealth.in
Website : www.starhealth.in ★ CIN : U66010TN2005PLC056649 ★ IRDAI Regn. No. : 129

STAR CANCER CARE GOLD (PILOT PRODUCT) Unique Identification No.: SHAHLIP18046V011718 Proposal Form - Unique Reference No: SHAI/PR0027	Ref. No.	
	Policy No.	

The Company will not be on risk until the proposal has been accepted and full payment of premium has been received.
Please fill up the form in block letters. Also submit photographs of each of the person proposed for insurance for issuance of identity cards

Policy Issuing Office :	SM CODE		SM NAME	
	AGENT CODE		AGENT NAME	

BUSINESS TYPE

Social Sector Classification* : ☐ Yes ☐ No

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

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 Mr / Mrs / Ms.		**Date of Birth :**
Occupation of the Proposer		**Annual Income Rs.:**
Residence Address		**Pin Code :**
Office Address		**Pin Code :**
Email ID		
Aadhar (UID) Number		**Period of Insurance** — **To**
GST Number		**PAN Number**

I would like to receive my insurance policy and all the information related to the proposed insurance policy through insurance repository ☐ Yes ☐ No

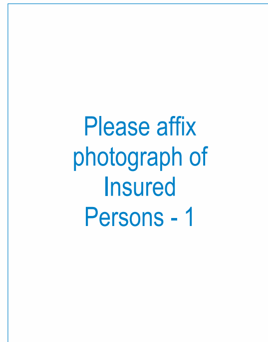
If you already have an e-Insurance Account (e-IA) number, kindly provide e-Insurance Account (e-IA) number ____________

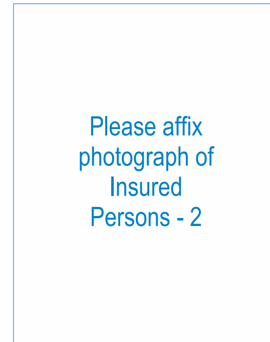
If no, choose any one Insurance Repository: ☐ KARVY ☐ CAMSRep - CAMS Insurance Repository & Services ☐ CIRL - Central Insurance Repository Limited ☐ NDML - NSDL Data Management Services limited

NOMINATION

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

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





Name : ____________________ Name : ____________________

Sum Insured Opted Insured Person 1	Rs.3,00,000/- ☐	Rs.5,00,000/- ☐
Sum Insured Opted Insured Person 2	Rs.3,00,000/- ☐	Rs.5,00,000/- ☐

Family Physician's Name ____________________

Phone____________________ Regn No____________________

Payments Details

Annual Premium Rs.			☐ Cash / ☐ Cheque / ☐ DD
Cheque / DD No. :	Date :	Drawn on :	Branch :

Bank Details of the proposer	Account Number :
	Type of Account : ☐ Savings ☐ Current ☐ Others please specify
	Name of the Bank :
	Name of the Branch :
	IFSC Code :

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

Please attach any of the following proof of Date of Birth

☐ Birth Certificate ☐ Voter ID ☐ PAN Card ☐ Driving License ☐ Aadhar Card ☐ Any other Govt. Recognised Proof

Insured person Details (Please fill in the respective column for each person proposed to be covered)

Details of the person proposed for insurance	Insured Person - 1	Insured Person - 2
Name		
Gender		
Date of Birth		
Height (cms)		
Weight (kgs)		
Relationship with proposer		
Occupation		
Annual Income (Rs.)		
Details of other previous Health Insurance policies ,If any		
1. Name of the Insurance Company		
2. Policy No.		
3. Period of Insurance		
4. Sum Insured (Rs)		
Details of Claims		
1. Ailment for which Claim was made		
2. Claim Amount Paid/rejected		
3. Year of Claim		

Signature of the Proposer

Insured person Details (Please fill in the respective column for each person proposed to be covered)

Health History	Insured Person - 1	Insured Person - 2
Please give answer in detail. A mere dash is not sufficient.		
1. 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		
2. Type and Stage of Cancer for which treatment have been taken		
3. Date of diagnosis of Cancer and Period of treatment		
4. Undergone any chemotherapy / Radiotherapy procedures?		
5. Undergone any surgery for cancer or precancerous lesions, If Yes give details		
6. Any complications during / following birth. (If yes, please submit all necessary documents)		
7. Has the person proposed for insurance 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 - please submit medical records.		

Signature of the Proposer

Proposal Form No. :

STAR Health Insurance — Personal & Caring — The Health Insurance Specialist

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Acknowledgement

Received the proposal for **Star Cancer Care Gold (Pilot Product)** from Mr/ Mrs/ Ms. ______________________________ along with payment of Rs. ______________/- by Cash / vide

Cheque/ DD No. ________________dt.______________ 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. 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.

Place :

Date : **Name & Code of the authorised person :** **Signature of the authorised person :**

Insured person Details (Please fill in the respective column for each person proposed to be covered)

Health History	Insured Person - 1	Insured Person - 2
d) Stroke, epilepsy, fainting attack, chronic headache, Parkinson's disease, Alzheimer's disease - 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) Any gynecological disorder such as DUB, Fibroid Uterus, Ovarian cyst - If Yes since when		
h) Disease of Stomach, Intestine, Liver, Gall Bladder / Pancreas, Kidney, Urinary bladder Urinary Tract Diseases - If Yes since when		
i) Disease of Prostrate /Fistula/Piles/Genital diseases? If Yes since when		
j) Cataract and other diseases of the Eye and ENT disease - If Yes since when		
k) Any Other Problem (Please Specify)		
8. Has the person proposed for insurance		
1. Been prescribed any medicines.		
2. Details of medicines and drugs prescribed.		
3. Period for these drugs are / were taken.		
4. Received /receiving any payment for any disability/injury/illness/disease		

Signature of the Proposer

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

Code : **Name :** **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.

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.

Submitted the above proposal for **Star Cancer Care Gold (Pilot Product)** 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 :

Where the Proposal Form is not filled by the proposer

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** **Signature / thumb impression of the proposer**

The contents of the proposal form and connected documents have been fully explained to me and I have fully understood the significance of the proposed contract.

Signature / Thumb impression 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.

PRO / SCCG / V.1 / 2017 - 18