STAR Health Insurance — Personal & Caring — 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

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 copy of the policy document by Email / Whatsapp / Any other electronic mode 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 Opted: 1 yr | 2 yrs | 3 yrs

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) 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. | **Quarterly instalment option is not available for Medi Classic Insurance Policy (Individual)

☐ Family Health Optima Insurance Plan**** Unique Identification Number: SHAHLIP22030V062122	☐ Medi Classic Insurance Policy (Individual)**** Unique Identification Number: SHAHLIP23037V072223	☐ Star Comprehensive Insurance Policy Unique Identification Number: SHAHLIP22028V072122	☐ Star Extra Protect – Add On Cover***** Unique Identification Number: SHAHLIA23061V012223
☐ Young Star Insurance Policy Unique Identification Number: SHAHLIP22036V042122	☐ Senior Citizens Red Carpet Health Insurance Policy Unique Identification Number: SHAHLIP22199V062122	☐ Star Health Gain Insurance Policy Unique Identification Number: SHAHLIP21262V032021	

Family Size A=Adult, C=Child: ☐ 1A ☐ 1A 1C+ ☐ 1A 2C+ ☐ 1A 3C+ / ☐ 2A ☐ 2A 1C+ ☐ 2A 2C+ ☐ 2A 3C+

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.

Applicable for Family Health Optima Insurance Plan - Number of Parents / Parents-in-law (as part of the same floater sum insured)

Sum Insured on Floater Basis in Lakhs* Rs.**

Applicable for Young Star Insurance Policy - Plan Opted for Family Floater ☐ Silver ☐ Gold

***Please check brochure for the available sum insured option in respect of each product.

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 :

**** POSP is applicable only for **Family Health Optima Insurance Plan** (Sum Insured restricted as **Rs.4,00,000/-** and **Rs.5,00,000/-**) and **Medi Classic Insurance Policy (Individual)** (Sum Insured restricted upto **Rs.5,00,000/-**)

***** The Star Extra Protect - Add on Cover is provided along with **Family Health Optima Insurance Plan** / **Medi Classic Insurance Policy (Individual)** / **Star Comprehensive Insurance Policy**

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.)					
Do you want Gold Plan [Applicable for Medi classic Insurance Policy (Individual)]		☐ Yes / ☐ No	☐ Yes / ☐ No	☐ Yes / ☐ No	☐ Yes / ☐ No	☐ Yes / ☐ No
Applicable for Young Star Insurance Policy - Plan Opted for Individual		☐ Silver / ☐ Gold	☐ Silver / ☐ Gold	☐ Silver / ☐ Gold	☐ Silver / ☐ Gold	☐ Silver / ☐ Gold
Sum Insured Opted (For Individual Policy) (Rs.)						
Applicable for Star Extra Protect - Add On Cover		☐ Section – I ☐ Section – II	☐ Section – I ☐ Section – II	☐ Section – I ☐ Section – II	☐ Section – I ☐ Section – II	☐ Section – I ☐ Section – II
If you opted Section II Choose the Aggregate Deductible		☐ Rs.25,000/- ☐ Rs.50,000/- ☐ Rs.1,00,000/-	☐ Rs.25,000/- ☐ Rs.50,000/- ☐ Rs.1,00,000/-	☐ Rs.25,000/- ☐ Rs.50,000/- ☐ Rs.1,00,000/-	☐ Rs.25,000/- ☐ Rs.50,000/- ☐ Rs.1,00,000/-	☐ Rs.25,000/- ☐ Rs.50,000/- ☐ Rs.1,00,000/-
Add-ons : [Applicable for Medi classic Insurance Policy (Individual)] - Do you want add on covers - If Yes, Please tick (✓) (Patient Care add-on is available only for Insured Persons above 60yrs of age.)		☐ Hospital Cash ☐ Patient Care	☐ Hospital Cash ☐ Patient Care	☐ Hospital Cash ☐ Patient Care	☐ Hospital Cash ☐ Patient Care	☐ Hospital Cash ☐ Patient Care
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 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 / received 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					
Applicable for **STAR COMPREHENSIVE INSURANCE POLICY** A) Buy back PED (Optional Cover) required?	☐ Yes / ☐ No	☐ Yes / ☐ No	☐ Yes / ☐ No	☐ Yes / ☐ No	☐ Yes / ☐ No
B) Does the Insured's Occupation require to engage in manual labour?					
C) Does the Insured Person engage in or propose to engage in any activity or sport which is hazardous or adventurous in nature such as Racing, Mountaineering, Winter sport etc if so please specify					
D) Name of the family member chosen for Personal Accident Insurance under Section-10 (Note : The sum insured for personal accidental cover (Accidental death & Permanent total disability) is equal to the sum insured opted for health cover. For person above 70years and dependent children the maximum sum insured is Rs.10,00,000/-)				Mr. / Ms.	
Note : If the proposer is interested to take PERSONAL ACCIDENT POLICY along with above mentioned health products, Kindly fill the Annexure A which is provided in a separate sheet					

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

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._____ 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 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:** **Name & Code of the authorised person:** **Signature of the authorised person:**

Applicable for (Star Extra Protect - Add On Cover) - Floater Sum Insured								
☐ Section – I	☐ Section – II			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
If you opted Section II – Choose the Aggregate Deductible	☐ Rs.25,000/-	☐ Rs.50,000/-	☐ Rs.1,00,000/-					

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 or from any past or present employer concerning anything which affects the physical or mental health of 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. 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.

Place	Date	Name	Signature / Thumb impression of the proposer:

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

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.**

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.

☐ Accident Care Individual Insurance Policy
UIN: IRDAI/HLT/SHAI/P-P/V.III/134/2017-18

☐ Accident Trauma Care Insurance Policy (Individual)
UIN: IRDA/NL-HLT/SHAI/P-P/V.I/136/13-14

☐ Family Accident Care Insurance Policy
UIN: SHAHLIP21042V012021

☐ POS - Accident Care Individual Insurance Policy
UIN: SHAHPAIP18070V031718

☐ Saral Suraksha Bima Star Health And Allied Insurance Co Ltd
UIN: SHAPAIP22039V022122

Details of the person/s proposed for insurance	Insured Person - 1	Insured Person - 2	Insured Person - 3	Insured Person - 4	Insured Person - 5
Name					
Please provide answers for the following questions **Applicable for Accident Care Individual Insurance Policy | POS - Accident Care Individual Insurance Policy | Family Accident Care Insurance Policy | Saral Suraksha Bima, Star Health And Allied Insurance Co Ltd**					
1) Does the occupation of the proposed persons require engaging in manual labour?	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
2) Does the proposed person engage in or propose to engage in racing on wheels or horse back, Big Game Hunting, Mountaineering, winter sports, skiing or ice Hockey, Ballooning, Polo or sports of similar nature or any other activities of similar nature. If yes give details					
3) Has/Is the proposed person suffered/ suffering from Physical defect or infirmity or any other disability. If yes give details.					
4) Has the person ever proposed for any personal accident insurance.	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
i) If yes details of Insurance Company, Period of Insurance and Sum Insured.					
5) Has any company Declined to issue a policy or Imposed any restrictions / special conditions					
6) Has the proposed person ever claimed or received compensation under any Accident Policy? If yes, give full details					
Applicable for Accident Care Individual Insurance Policy | POS - Accident Care Individual Insurance Policy					
What is the monthly income from Gainful Employment (in Rs.)					
Risk Group I - Persons engaged primarily in administrative functions. **Risk Group II** - Persons engaged in manual work other than what is specifically provided for under Risk Group III **Risk Group III** - Persons working in explosives industry, mine and /or Magazine workers, high tension electric supply, horse racing including jockeys, athletes and occupations of similar hazard	☐ Risk Group I ☐ Risk Group II ☐ Risk Group III	☐ Risk Group I ☐ Risk Group II ☐ Risk Group III	☐ Risk Group I ☐ Risk Group II ☐ Risk Group III	☐ Risk Group I ☐ Risk Group II ☐ Risk Group III	☐ Risk Group I ☐ Risk Group II ☐ Risk Group III
Table A - Sum Insured (Rs.)					
Table B - Sum Insured (Rs.)					
Table C - Sum Insured (Rs.)					
Medical Expenses Extension (Optional Benefit)	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
Hospital Cash (Optional Benefit)	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
Home convalescence (Optional Benefit)	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
Winter Sports/Rallies (Optional Cover)	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
Applicable for Family Accident Care Insurance Policy					
1) Sum Insured Opted (Rs)					
Applicable for Saral Suraksha Bima, Star Health And Allied Insurance Co Ltd					
1) Sum Insured for Base Cover (Rs)					
2) Hospitalization Cover due to Accident (Optional Cover)	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
3) Educational Grant(optional Cover)	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
4) TTD (Optional Cover)	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
Applicable for Accident Trauma Care Insurance Policy (Individual)					
1) Sum insured Opted (Rs) - Section I & Section II					
2) Do you wish to cover Accidents at work place?	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
i) If Yes, please furnish details of nature of work and location of the workplace					
3) Please furnish details of other similar insurance/s taken					
4) Any proposal for this insurance or any other such insurance refused, cancelled or higher premium charged. If so provide details					
5) Has any claim been rejected by the previous Insurer? If Yes, please provide details	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No	☐ Yes | ☐ No
6) In last 3 years have any of these persons who proposed for insurance					
i) Has any life / Health / disability / cover declined / modified / postponed					
ii) Been advised to surgery but not yet done					
iii) Received payment for disability / illness / injury					
iv) Been treated as inpatient or out patient for surgery					
v) Had any medical treatment, mental or physical impairment					

Signature / Thumb impression of the Proposer: