

Part -1

Name of the Policy Holder/Insured(s):					
Date of Birth:	D D/M M/Y Y Y Y	Age:	(Years)	(Months)	
Email:				Mobile No:	
Address of the policyholder/insured:					
City:	Pin Code:		State:		

i.	Name of the existing insurer		
ii.	Name of the product proposed/intend to take		
iii.	Sum Insured Proposed		
iv.	Whether Cumulative Bonus to be converted to an enhanced sum insured		
v.	Type of Policy	Individual []	Floater []

vi. Give only those of the members who want porting-out						
Name of person	Gender M/F/TG	Aadhar No.	Pan No.	Member ID under expiring policy	Date of Birth	Completed Age in years
Name of person	Sum insured under the expiring policy		Cumulative Bonus	Claims experience	No of years of continuous coverage including that under the expiring policy	

i.	Name of the product proposed/intend to take	
i.	Sum Insured Proposed	
ii.	Whether Cumulative Bonus to be converted to an enhanced sum insured	

☐ Service problem	☐ Product is not suitable.	☐ Dissatisfied with existing insurer
☐ Policy servicing by current insurer is not good.	☐ Price is better	☐ Delay in policy issuance
☐ Renewal notices not received.	☐ Wider coverage available with new insurer	
☐ Claim not handled properly.	☐ Delay in claim settlements	
☐ Existing agent not providing service.	☐ Premium rates with existing insurer is high/costly	
☐ Wrong repudiation of claims by current insurer	☐ Wrong deductions in claims/Claims settled for less amounts	
☐ Any Other		

Enclosure: Photocopy of the existing policy documents	
Date: D D/M M/Y Y Y Y	Signature of the Policy Holder

PART-II

1. Whether the Pre Existing Disease (PED) exclusions/ time bound exclusions have longer exclusion period than the existing policy:

Yes []

No[]

2. If Yes, please give written consent to the declaration below:

I am aware that the waiting period for the following disease(s)/treatment(s) is days/ years more than the previous policy terms.

I hereby agree to observe the additional waiting period for the following disease(s)/ treatment(s)

In case of any change in the information furnished in the proposal form (attached herewith) regarding member(s) details/ health status and claims Subsequent to the date of this application, I shall communicate to the insurer before inception of this policy

Date: D D/M M/Y Y Y Y

Place:

Signature of the Policy Holder