

Star Women Care Insurance Policy
Unique Identification Number: SHAHLIP27051V032627

Policy Type (Please ✓) ☐ Individual ☐ Floater

Sum Insured on Floater Basis in Lakhs** Rs.

Star Health Assure Insurance Policy
Unique Identification Number: SHAHLIP26048V032526

Family Size 1A 1A+ 1C+ 1A 2A+ 2A 2C+ 3C+ 3C

Sum Insured on Floater Basis in Lakhs** Rs.

Star Health Premier Insurance Policy
Unique Identification Number: SHAHLIP22226V012122

Mode of Payment Cheque Debit Card NEFT DD Credit Card Cash

Sum Insured on Floater Basis in Lakhs** Rs.

Applicable for Star Health Assure Insurance Policy Floater Sum Insured
Number of Parents / Parents-in-law (as part of the same floater sum insured)
Do you wish to choose Deductible option ☐ Yes ☐ No

If yes, choose Deductible Option (Please Tick) ☐ Rs.50,000/- ☐ Rs.1,00,000/-

Applicable for Star Health Premier Insurance Policy
Do you want to opt for Optional Cover ☐ Yes ☐ No
If yes, choose anyone option ☐ Reduction of Co-pay ☐ Waiver of Co-pay

Details of the person/s proposed for Insurance

Name

Gender

Height (cms)

Relationship with proposer

Occupation

Sum Insured Opted (For Individual Policy) (Rs.)

Applicable for Star Women Care Insurance Policy (ABHA) No.

Do you want optional Cover (Applicable only for Females) If yes, Please mention Sum Insured Opted (Rs.) for Optional Cover

Applicable for Star Health Assure Insurance Policy (Individual Policy) Do you wish to choose Deductible option If yes, choose deductible (Rs.)

1. Name of the Insurance Company and Policy No

2. Period of Insurance

3. Sum Insured (Rs)

Kindly disclose all the health insurance policies under which the lives proposed for insurance are covered. The company reserves the right to cancel any / all of my policies (except the 1st issued Policy) ab-initio, in case of any non-disclosure of my previous policies and / or having multiple policies that exceeds the maximum Sum Insured filed as per the Product.

Details of claims

1. Allment for which claim was made

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

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 separate sheet along with this proposal form.

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 / 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

Applicable for STAR WOMEN CARE INSURANCE POLICY (Specific Questions for Female)

A) Is the person proposed for insurance presently pregnant? (If Yes, please submit the scan reports taken during 12th and 20th week of Pregnancy period, at Star Health specified scan centres and mention the expected date of delivery). Applicable for Female Insured Persons

B) Any complaint of Diabetes. Hypertension or any complication during current or earlier pregnancy?

C) Has the person proposed for insurance ever undergone hysterectomy or ever had any disease of uterus, cervix or ovaries?

D) Is the Person Proposed for Insurance is a Surrogate Mother

E) Is the Person Proposed for Insurance is a Oocyte Donor

F) Is the Person Proposed for Insurance is Surrogate Mother and also Oocyte Donor

G) Date of first initiation of treatment / procedure (Policy inception will happen from this date)

H) History of Oocyte donation, if any

I) History of Surrogacy, if any

Declaration of the Agent/Intermediary : / 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)

Star Health Assure Insurance Policy
Unique Identification Number: SHAHLIP26048V032526

1A 1A+ 1C+ 1A 2A+ 2A 2C+ 3C+ 3C

Premium Amount Rs.

Star Health Premier Insurance Policy
Unique Identification Number: SHAHLIP22226V012122

Mode of Payment Cheque Debit Card NEFT DD Credit Card Cash

Sum Insured on Floater Basis in Lakhs** Rs.

Star Health Assure Insurance Policy
Unique Identification Number: SHAHLIP26048V032526

Account Number

Type of Account Savings Account Current Account

Bank Details of the Proposer

Others Please Specify

Star Health Premier Insurance Policy
Unique Identification Number: SHAHLIP22226V012122

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Sum Insured on Floater Basis in Lakhs** Rs.

Insured Person - 1

M / F / Transgender

DD/MM/YYYY

KGS

CMS

KGS

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

Insured Person - 2

M / F / Transgender

DD/MM/YYYY

KGS

CMS

KGS

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

Insured Person - 3

M / F / Transgender

DD/MM/YYYY

KGS

CMS

KGS

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

Insured Person - 4

M / F / Transgender

DD/MM/YYYY

KGS

CMS

KGS

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

Insured Person - 5

M / F / Transgender

DD/MM/YYYY

KGS

CMS

KGS

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

Family Physician's Name:

Phone:

Regn No:

Please attach a photo copy of cancelled cheque leaf

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Insured Person - 2

M / F / Transgender

DD/MM/YYYY

KGS

CMS

KGS

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

Insured Person - 3

M / F / Transgender

DD/MM/YYYY

KGS

CMS

KGS

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

Insured Person - 4

M / F / Transgender

DD/MM/YYYY

KGS

CMS

KGS

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

Insured Person - 5

M / F / Transgender

DD/MM/YYYY

KGS

CMS

KGS

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

M / F / Transgender

DD/MM/YYYY

Family Physician's Name:

Phone:

Regn No:

Please attach a photo copy of cancelled cheque leaf

*Please refer and fill Annexure to Proposal Form - Star Health Assure Insurance Policy for Health Questionnaire discount. Common Proposal Form - 2 3 of 4