Proposal Form No.: 097024



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 | S0161130 |
| SM NAME | DIRECT |
| AGENT / CORPORATE AGENT / BROKER / IMF / CODE | OL-32 |
| AGENT / CORPORATE AGENT / BROKER / IMF / NAME | J.S.P.S |

Please affix Passport size photograph of the Proposer

## PROPOSER DETAILS

| | Prefix | First Name | Middle Name | Last Name |
|---|---|---|---|---|
| Proposer Name (same as KYC/ID proof) | MR | AJAY | ARVIND | SHEVADE |
| Father / Spouse Name | | | | |
| Mother Name | | | | |

Date of Birth: 08/07/1961 | Gender: ✓ Male | Female | Transgender | Occupation: SELF EMPLOYED

**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.): 7,50,000/-

PAN Number[†]: ANCPS6461Q

If PAN number is not available submit Form 60[†]

GST Number

Residential Status: Indian Resident | NRI | PIO | Foreign National

CKYC Number

Email ID: AJAY.SHEVADE5@GMAIL.COM

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 | | A2/108 SHALIMAR | |
| Address line 2 | | FORTLIZA NEAR ASHIMA MALL | |
| City / Town / Village | | BHOPAL | |
| District | | | |
| State | | MADHYA PRADESH | |
| Country and Pincode | | INDIA 462026 | |
| Mobile Number / Alternate Mobile Number | | 7999700522 | |

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: KANCHAN SHEVADE | Relationship to Proposer: SPOUSE | Date of Birth: 27/06/1961 | Age: _ in yrs

Name of the Appointee (if nominee is a minor): | Relationship to Nominee: | Date of Birth: DD/MM/YYYY | 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 24/04/2023 To 23/04/2024

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.

☐ Star Women Care Insurance Policy
Unique Identification Number: SHAHLIP23132V022223

☑ ~~Star~~ Health Assure Insurance Policy
Unique Identification Number: SHAHLIP23131V022223

☐ Star Health Premier Insurance Policy
Unique Identification Number: SHAHLIP22226V012122

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Policy Type (Please ✓) | ☑ Individual | ☐ Floater | Family Size A=Adult, C=Child | ☑ 1A | ☐ 1A 1C+ | ☐ 1A 2C+ | ☐ 1A 3C+ | Premium Amount | Rs. 28,568/- | Mode of Payment | ☐ Cheque ☐ Debit Card ☐ NEFT |
| Sum Insured on Floater Basis in Lakhs** | Rs. 10LAKH | | | ☐ 2A | ☐ 2A 1C+ | ☐ 2A 2C+ | ☐ 2A 3C+ | | | | ☐ DD ☑ ~~Credit~~ Card ☐ Cash |
| | | | | | | | | | | | ☐ ECS ☐ CC Mandate (Cash payments are not eligible for the 80D tax benefits) |

**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/- |

**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**

Cheque / DD No. :
Date : D D M M Y Y Y Y
Branch :
Please attach a photo copy of cancelled cheque leaf

**Details of the person/s proposed for insurance**

| | Insured Person - 1 | Insured Person - 2 | Insured Person - 3 | Insured Person - 4 | Insured Person - 5 |
|---|---|---|---|---|---|
| Name | AJAY ARVIND SHEVADE | | | | |
| Gender / Date of Birth | M / 08/07/1961 | 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) | 176 CMS / 78 KGS | CMS / KGS | CMS / KGS | CMS / KGS | CMS / KGS |
| Relationship with proposer | SELF | | | | |
| Occupation / Annual Income (Rs.) | SELF EMPLOYED / 7.5LAKH | | | | |
| Sum Insured Opted (For Individual Policy) (Rs.) | 10LAKH | | | | |
| Applicable for Star Women Care Insurance Policy Do you want optional Cover (Applicable only for Females) If yes, Please mention Sum Insured Opted (Rs.) for Optional Cover | ☐ Yes / ☐ No | ☐ Yes / ☐ No | ☐ Yes / ☐ No | ☐ Yes / ☐ No | ☐ Yes / ☐ No |
| Applicable for Star Health Assure Insurance Policy (Individual Policy) Do you wish to choose Deductible option If yes, choose deductible (Rs.) | ☐ Yes / ☐ No; ☐ Rs.50,000/- ☐ Rs.1,00,000/- | ☐ Yes / ☐ No; ☐ Rs.50,000/- ☐ Rs.1,00,000/- | ☐ Yes / ☐ No; ☐ Rs.50,000/- ☐ Rs.1,00,000/- | ☐ Yes / ☐ No; ☐ Rs.50,000/- ☐ Rs.1,00,000/- | ☐ Yes / ☐ No; ☐ Rs.50,000/- ☐ Rs.1,00,000/- |
| Existing Insurance Coverage with us and/or any other company give details: 1. Name of the Insurance Company | CARE | | | | |
| 2. Period of Insurance | 24-03-2018 To 23-04-2023 | | | | |
| 3. Sum Insured (Rs) | 5LAKH | | | | |
| 4. Policy No. | 12285998 | | | | |
| Details of Claims: 1. Ailment for which Claim was made / Year | NO | YYYY | YYYY | YYYY | YYYY |
| 2. Claim Amount Paid / Rejected | NO | | | | |
| Have you ever been declined health insurance coverage due to a diagnosis of a health condition? | NO | | | | |

**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 | YES | | | | |
| 2. Has the person proposed for insurance consulted / diagnosed / taken treatment / been admitted for any illness / injury. If yes, give details | NO | | | | |
| 3. Does the person proposed for insurance have any complications during / following birth. If yes, please submit all necessary documents. | NO | | | | |
| 4. Whether the insured person is pregnant if yes, kindly provide duration of pregnancy and scan reports. | NO | | | | |
| **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. | YES - 1YEARS | | | | |
| b) High BP/ Cholesterol – if yes, mention duration/date of diagnosis and medication details | YES - 6YEARS | | | | |
| c) Thyroid disorders, specify diagnosis Hypo / Hyperthyroid / Autoimmune thyroiditis, Goitre etc), duration/date of diagnosis and medication details | NO | | | | |
| 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) | NO | | | | |
| 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 | NO | | | | |
| f) Tuberculosis, asthma, COPD, ILD, other respiratory diseases if yes, mention – duration/date of diagnosis and medication details | NO | | | | |

| | | | | | |
|---|---|---|---|---|---|
| g) Disease of bones/joints, slipped disc, spinal disorder, injury to ligaments – if yes, mention duration/date of diagnosis and operation or treatment details | NO | | | | |
| 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 | NO | | | | |
| 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 | NO | | | | |
| j) Treatment for sub-fertility or has been advised for? (answer if applicable – if yes, mention duration/date of diagnosis and medication details | NO | | | | |
| k) Disease of stomach, intestine, liver, gall bladder / Pancreas, Piles / Fistula / Fissure / Hernia if yes, mention duration/date of diagnosis and medication details | NO | | | | |
| l) Disease of kidney, urinary bladder, urinary tract disease, Calculi- if yes, duration/date of diagnosis and medication details | NO | | | | |
| m) Disease of prostate / hydrocele / genital disease / - if yes, mention duration/date of diagnosis and medication details | NO | | | | |
| 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 | NO | | | | |
| o) Cancer, Precancerous lesions, Non-healing ulcers – if yes, mention type of cancer, duration/date of diagnosis and treatment details | NO | | | | |
| p) Any blood disorder, specify the diagnosis, mention duration/date of diagnosis and medication details | NO | | | | |
| 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. | NO | | | | |
| r) Any other Health problems/diseases please specify | HERNIA OPRATED 13 YEAR BACK<br>HAD NORMAL INJURY 5 YEAR BACK | | | | |
| **6. Has the person proposed for insurance** | | | | | |
| a) Undergone any medical test? | NO | | | | |
| b) Prescribed any medicines? If yes<br>1. Name the illness for which medicines have been prescribed | DIABETES, BP | | | | |
| 2. Details of medicines and drugs prescribed | OLMIN 20 LN | | | | |
| 3. Period for which these drugs were taken | 1YEARS, 6YEARS | | | | |
| c) Been advised for any surgery/treatment? – If yes, give details | NO | | | | |
| d) Received / received any payment for any disability / injury / illness / diseases. Give details | NO | | | | |
| **7. Does the person proposed for insurance has any of the mentioned habits** | | | | | |
| a) Chew Tobacco - If yes, since when | NO | | | | |
| b) Smoke - If yes, since when | NO | | | | |
| c) Consume Alcohol - If yes, since when | NO | | | | |
| d) If a, b and c, are mentioned as yes, mandatory to give details whether diagnosed with any local or systemic disease / complications. | NO | | | | |
| 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 | NO | | | | |
| 9. Type and the total number of medical documents provided | NO | | | | |
| **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 Pregnency period, at Star Health specified scan centres and mention the expected date of delivery). Applicable for Female Insured Persons | ☐ Yes / ☑ No | ☐ Yes / ☐ No | ☐ Yes / ☐ No | ☐ Yes / ☐ No | ☐ Yes / ☐ No |
| B) Any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy? | NO | | | | |
| C) Has the person proposed for insurance ever undergone hysterectomy or ever had any disease of uterus, cervix or ovaries? | NO | | | | |

| 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 | Signature of the Agent / Specified Person of Corporate Agent / Broker Qualified Person / Insurance Sales Person of the IMF |
|---|---|---|---|---|
| | 18/04/2023 | OL-32 | J.S.P.S | |

| 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 |
|---|---|---|---|---|
| | | | | |

Submitted the above proposal for HEALTH ASSURE policy along with payment of Rs. 28,568/- 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 |
|---|---|---|
| DELHI | 18/04/2023 | AJAY ARVIND SHEVADE |

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.

IRVANCP2LC

# STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

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

## Application for Portability Form - Part I

**Details of the Proposer**

Name of the Policyholder / Proposer : Ajay Arvind Shevade. Male / Female - Male Address :- A2/708 Shalimar Fortliza Near Ashima Mall Bhopal 462026. Mobile-..... Off / Res ..... Email Id (to be filled-in if updates are desired.).....

**Details of the Existing Insurer**

Name of the existing Insurer CARE Policy No 12285998 Period of Insurance From .....24-03-2018...To .....23-04-2023.....

Name of the Product Care Shield Policy... ..... IRDAI Product ID..... Type of Policy ( ✔ ) : Individual - N/ Floater Y

**Details of the Person Covered****

| Name of the persons | Gender | Aadhar No. | Pan No. | Member ID under expiring policy | Date of Birth | Age in Completed years |
|---|---|---|---|---|---|---|
| Ajay Arvind Shevade | M | | | | 08.07.1961 | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| Name of the persons | No of years of continuous coverage including that under the expiring policy | Sum insured under the expiring policy | Cumulative Bonus | Claims experience |
|---|---|---|---|---|
| Ajay Arvind Shevade | Since2018 | 5L | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

** Give only those of the members who want porting-out.

**Details of the proposed insurance**

Name of the Insurer STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED Name of the product proposed/ intended to be taken .....Health Assure .....

Whether Cumulative Bonus to be converted to an enhanced Sum Insured ☒ No

**Reasons for Portability (Tick whichever is applicable):**

☐ **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

Part II

- I have understood the difference between the expiring policy with M/S...Care ..... and the proposed policy with M/S Star Health and Allied Insurance Co. Ltd. especially relating to preexisting disease exclusions, time bound exclusions and other terms and conditions.
- I also give my consent to the proposed insurer to access my previous policy and claims details through my previous insurers / Insurance information Bureau of India.
- I understand in the event of my renewal of existing policy with the present insurer also the new policy now issued by the new Insurer will not be treated as a ported policy
- 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

**Place : New Delhi** **Date: 18-04-2023** **Signature of the proposer:**

**Please note the following**

For availing the portability benefits, please submit the following documents in addition to portability form duly filled.

- Self attested copies of the previous year's policy schedule (s).
- Proposal form duly filled and signed in all, respects.
- Details of existing and previous policies. (Please furnish the details in the enclosed sheet)

## Additional Declaration

I confirm having filled up and signed the proposal and portability forms, proposing to port the policy number 12285998 Insured with CARE For 5 year(s) to STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED.

**I further confirm after reading /explained by the sales wing, that none of the insured person(s) has/have been diagnosed with (or) treated for (or) hospitalized for any aliment/disease/illness or for any accidental injury other than those that have been mentioned in the proposal form.**

Place: New Delhi Date: 18-04-2023 Signature of the Proposer

**Note:**

**Please have a re-look of your proposal. 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 the repudiation of the claim/cancellation of the policy. The other option for you is to continue with the existing insurer.**