



Form No. **A C I P 0 6**

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Corporate Office : 1, New Tank Street, Valluvarkottam High Road, Chennai - 600 034.

ACCIDENT CARE (INDIVIDUAL) PROPOSAL FORM

PROPOSAL NO. : **AC/** Issuing Office : _____

Premium Payment Details : Cash Cheque DD Cheque/DD No. _____ Date _____

Coverage Required : From **DDMMYY** To **DDMMYY** Dep. Pre. Rt. No. _____ Date _____

Bank Name/Branch _____

Mktg. Officer Name _____ Code No _____

Agents Name : _____ Code No _____

Corporate Agent's _____ Code No _____

The Company will not be on risk until the Proposal form has been accepted and full payment of premium made. The liability of Star Health and Allied Insurance Company commences only upon the acceptance of this proposal notwithstanding the payment of any deposit. Please fill up the form in BLOCK letters. Insured persons above the age of 18 years and less than 70 years only be covered. If you are in any doubt about the information to be given, please seek the advice and guidance from your insurance advisor or agent.

Business Type Urban Rural Sector : _____

1. PROPOSER DETAILS Mr. Mrs. Ms.

Name of Proposer First Name _____ Middle Name _____ Last Name _____

Permanent Address _____

City/Taluk _____ District _____ State _____ Pin Code _____

Address for Communication _____

City/Taluk _____ District _____ State _____ Pin Code _____

STD Code _____ Phone No. _____ Fax _____ Cell _____

E-mail _____ IT Pan No. _____

Marital Status of Proposer Single Married

Educational Qualification _____ Occupation _____

Existing SHAICL Customer Yes No If yes, Customer Code No : _____

2. DETAILS OF PERSON(S) TO BE COVERED INCLUDING PROPOSER

	1	2	3	4
Name of the Person to be Insured (Insured Person)	_____	_____	_____	_____

Relationship with the Proposer	_____	_____	_____	_____
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Date of Birth	_____ Age _____	_____ Age _____	_____ Age _____	_____ Age _____
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Educational Qualification* **NM M G PG PC NM M G PG PC NM M G PG PC NM M G PG PC**

(NM - Non-Matric, M-Matric, G-Graduate, PG - Post Graduate, PC - Professional Course)

Ht. in mtrs & wt in Kgs.	Ht. _____ Wt. _____	Ht. _____ Wt. _____	Ht. _____ Wt. _____	Ht. _____ Wt. _____
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Profession/Occupation/ Trade or Business of the Insured person. (Please describe fully with nature of duties)

_____	_____	_____	_____
_____	_____	_____	_____



Does your Occupation require you to engage in Manual Labour

	1		2		3		4	
	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N

Do you engage in or propose to :

- | | | | | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. racing on wheels or horse back | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| b. Big game hunting | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| c. Mountaineering | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| d. Winter Sports, Skiing or Ice Gockey | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| e. Ballooning or Polo or sports of similar nature & any other activities of similar nature | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N |

What is your average

Monthly Income from :

	Rs.	Rs.	Rs.	Rs.
1. Gainful Employment	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Other Sources	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. Total	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Have you ever suffered or do you suffer from :

- | | | | | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Any physical defect or infirmity. | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| b. Gout or diabetes, paralysis, fits of any kind or any other chronic disease. | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| c. Any other disability | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N |

(full particulars must be given in case the answer to any of the above questions are YES)

Have you ever proposed any Personal Accident Insurance ?

Y N

If yes, details of :

Name of the Insurance Company

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Period of Insurance

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Sum Insured

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Has any company :

- | | | | | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1. Declined to issue a policy to you ? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Imposed any restrictions or special conditions. | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> N |

If yes, details of :

Name of the Insurance Company

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Address

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Have you ever claimed or received compensation under any Accident Policy ?

Y N Y N Y N Y N

If so, give full particulars, Name of the Insurer, Amount and dates

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RISK GROUP

- Group I Persons engaged primarily in administrative functions
- Group II Persons engaged in manual work other than what is specifically provided for under group III
- 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.

RATING TABLE

COVERAGE/RISK GROUP	GROUP 1	GROUP 2	GROUP 3
Table I	0.45 per mille*	0.60 per mille	0.80 per mille
Table II	0.80 per mille	1.30 per mille	1.75 per mille
Table III	1.25 per mille	1.75 per mille	2.00 per mille

* per mille means per thousand sum insured

Medical Expenses Extension : 10% of policy premium

Family package discount : 10%