STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Registered Office: No. 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034. Phone : 044 - 28288800
Corporate Office: No. 148, Acropolis, Dr. Radha Krishnan Salai, Mylapore, Chennai - 600 004. Phone : 044 - 4788 6666
Email: support@starhealth.in | **Website:** www.starhealth.in | **CIN:** L66010TN2005PLC056649 | **IRDAI Regn. No.:** 129

Application for Portability Form - Part I

Details of the Proposer

Name of the Policyholder / Proposer ..... Gender: Male / Female..... Address.....

.....

Mobile ..... Off / Res ..... Email Id (to be filled-in if updates are desired.).....

Details of the Existing Insurer

Name of the existing Insurer ..... Policy No. .....Period of Insurance From..... To .....

Name of the Product .....IRDAI Product ID .....Type of Policy (✔) : Individual ☐ / Floater ☐

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

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

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

Details of the proposed insurance

Name of the Insurer ..... Name of the product proposed/ intended to be taken .....

Whether Cumulative Bonus to be converted to an enhanced Sum Insured ☐ Yes / ☐ 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. ..... 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: **Date:** **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)

ACKNOWLEDGEMENT

Received the Portability and the Proposal form from Mr./ Ms. ..... For coverage under our .....policy.

Place: **Signature:**

Date: **Name of the Insurer:**

Details of Previous Insurance for the last 4 years									
		Under expiring policy		Under preceding 1st year policy		Under preceding 2nd year policy		Under preceding 3rd year policy	
S. No.	Name of the Insured	Name of Insurer	Policy no.	Name of Insurer	Policy no.	Name of Insurer	Policy no.	Name of Insurer	Policy no.
1									
2									
3									
4									
5									

P.T.O...

Additional Declaration

I confirm having filled up and signed the proposal and portability forms, proposing to port the policy number _____ Insured with _____ for ____ 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: Signature of the Proposer

Date:

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.