Form No: S T 1 0 6

484043

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

STAR Personal and Caring

Regd. & Corporate Office :
1, New Tank Street, Valluvar Kottam High Road, Nungambakam, Chennai - 600 034.

STAR TRAVEL INSURANCE PROPOSAL

Marketing Officer Name _____

Marketing Officer Code _____

Agent Name _____

Agent Code _____

Broker Name _____

Broker Code _____

Issuing Office Address :

IMPORTANT

PLEASE MAKE SURE YOU READ AND FULLY UNDERSTAND THIS DOCUMENT BEFORE YOU TRAVEL FROM THE REPUBLIC OF INDIA. THE PROPOSAL FORM SHOULD BE COMPLETED TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, AND ALL QUESTIONS SHOULD BE ANSWERED.

INSURED DETAILS

Insured Name : Mr/Mrs. _____

Gender Male/Female. Date of Birth _____ Age _____

Passport No. _____ Expiry Date _____

Occupation _____

Local Address _____

Address Abroad _____

Telephone No. _____

Mobile No. In India _____ While Overseas: _____

E-mail Id. _____

PLAN TYPE (TICK YOUR OPTION)

STAR TRAVEL PROTECT (INDIVIDUAL)

WORLDWIDE INCLUDING USA AND CANADA		WORLDWIDE EXCLUDING USA AND CANADA	
PLAN A1 : USD 50000		PLAN A2 : USD 50000	
PLAN B1 : USD 100000		PLAN B2 : USD 100000	
PLAN C1 : USD 250000		PLAN C2 : USD 250000	
PLAN D1 : USD 500000		PLAN D2 : USD 500000	

STAR FAMILY TRAVEL PROTECT

WORLDWIDE INCLUDING USA AND CANADA		WORLDWIDE EXCLUDING USA AND CANADA		ASIA PLAN EXCLUDING JAPAN & HONGKONG	
FLY A1 : USD 50000		FLY A2 : USD 50000		FLY A3 : USD 10000	
FLY B1 : USD 100000		FLY B2 : USD 100000		FLY B3 : USD 25000	
FLY C1 : USD 250000		FLY C2 : USD 250000		FLY C3 : USD 50000	

STAR CORPORATE TRAVEL PROTECT (Worldwide)		STUDENTS PLAN	
CTP 1 : USD 100000		STP 1 : USD 50000	
CTP 2 : USD 250000		STP 2 : USD 100000	
CTP 3 : USD 500000		STP 3 : USD 250000	

TRAVEL DETAILS

1) Does your trip include USA &/Or CANADA [Y] [N]

2) Countries to be visited

1. _____

2. _____

3. _____

3) How Frequently do you travel overseas? _____

4) Date of Departure from India _____

5) Date of return to India _____

6) No. of Days _____

7) Purpose of Visit : Business / Holiday / Study / Others

8) Nature of Visa: _____

PAYMENT / INSURANCE DETAILS:

Payment Mode : Cash/Cheque/DD/Credit Card

Cheque No: _____

Cash _____

DD No. _____

Payable at _____

Credit Card No. _____

Date _____

ADDITIONAL INSURED FAMILY MEMBERS (Spouse or dependent children) (applicable only for Family Coverage)

Sl. NO.	Name	Gender	Date of birth	Passport No.	Assignee Name	Relationship

No refund of premium is Permissible in case you return to India before the expiry date In case of any extension of stay abroad necessitating extension of Policy period, approval of issuing office must be obtained and appropriate premium paid before expiry of policy. Request for such extension should be supported with a declaration of good health.

FAMILY PHYSICIAN DETAILS

Name _____

Regn. No. _____ Qualification _____

Address _____

_____

Telephone No: _____

E-mail ID : _____

II Medical History

Please answer these questions clearly, completely and truthfully Failure to do so may prejudice your claim

Are you suffering or have you ever suffered from any illness/ disease up to the time of making this proposal?	
Do you have any physical defect or deformity?	
Have you ever been hospitalized for treatment/ observation? If So, please furnish details.	
Are you currently or in the past have been on Medication ? Please furnish details.	
Have you suffered from any illness or had an Accident in the preceeding 12 Months?	

III Medical History of the proposer to be completed by M.D. Cardiologist

1. Medical History	
2. Any Past History of Disease, Operation	
3. How frequently the proposer would visit you for advice/treatment?	
4. From the Lab reports ECG, Fasting and Post Prandial Blood Sugar Report, Urine Strip Report and Cholestrol Profile, do you consider that the Proposer is fit to undertake Travel Abroad?	

Date :

Signature of the Doctor with Registration Number

I hereby declare that I am not travelling against the advice of the Physician and will not be travelling for the purpose of obtaining medical treatment. I understand that this Policy does not cover any pre-existing medical condition/injury/illness/deformity and any complications arising there from whether declared or undeclared. I authorize STAR Health and Allied Insurance Co. Ltd. to seek any information relating to my physical and mental health and I authorize that Doctor to give such information to the STAR Health and Allied Insurance Co. Ltd and to authorized Claims Administrator of the STAR Health and Allied Insurance Co. LTD

I hereby declare and aver that the details furnished above are true and complete in all respects and all material information pertaining to me and medical history have been disclosed to you.

I agree to this proposal and this declaration shall be the basis for this contract between me and STAR Health and Allied Insurance Company Limited.

I agree that any misrepresentation of any material information given above would make this contract null and void.

Date :

Signature of the Proposer

ADDITIONAL INFORMATION TO BE COMPLETED BY THE STUDENT (ONLY FOR STAR STUDENT TRAVEL PROTECT)

Name of the Student	
Date of birth	
Name of the Institution where the student proposed to study	
I-20 Number / Copy of admission letter as applicable	
Detailed address of the Institution/Telephone No. & name of the student contact person at the institution	
Course Duration : please give : Date of commencement Date of conclusion	
Number of Semesters	
Tuition fees per Semester (Please give the detail breakup)	
Tuition financed by (Self, parents, borrowing from bank or FI's) please give details	
Internship Period	Y N
If sponsored by persons/bodies other than above a) Name of the Sponsor b) Address c) Phone No./ E-mail Id	
Have you undergone medical examination/ fitness test? If Yes attach report	Y N
Would like to state any thing that is not asked which you may want the insurer to know ?	

Signature of the Proposer