



Star Health and Allied Insurance Co. Ltd.

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road,
Nungambakkam, Chennai – 600034.
Phone : 044 – 28288800 Telefax : 044 – 28260062 Website : www.starhealth.in

PORTABILITY FORM PART I

Name of the policyholder / Insured (s) : _____

Address of the policyholder / Insured : _____

Telephone No. : _____ Email ID : _____

Details of the existing Insurer

Name of the Insurer : _____

Name of the Product : _____

Policy number : _____ Add-ons / Riders taken : _____

Details of the proposed Insurance

Name of the product Proposed / intend to take : _____

Sum Insured Proposed : Rs. _____ Whether Cumulative Bonus to be converted to an enhanced sum insured : Yes No

Reason (s) for Portability : _____

Number of family members to be included in the policy to be ported : _____

Name of the family member	Member ID	DOB / Age	No. of years of continuous coverage	Sum Insured (Rs.)	Cumulative Bonus

Signature of policyholder _____

Date : _____

PART II

- Whether the PED exclusions / time bound exclusions have longer exclusion period than the existing policy: Yes No
- If yes, please give written consent to the declaration below:

“I am aware that the waiting period for the following disease(s) / treatment(s) is _____ days / years more than the previous terms. I hereby agree to observe the additional waiting period for the following disease(s) / treatment(s)”

Signature of policyholder _____

Date : _____

PART III

I understand that my proposal to cover the person under portability is considered by Star Health and Allied Insurance Co. Ltd based on the details furnished by me in the proposal form & portability form and I declare that the details furnished are true & correct. In the event of the details furnished by me is at variance from the details that will be obtained from my previous insurer under the portability system, my policy will be cancelled or will be subject to endorsements amending the scope of cover at the discretion of Star Health and Allied Insurance Co. Ltd.

If I have asked for an increase in sum insured I understand and agree that the enhanced sum insured that is being given on my request will not be available for any illness, diseases, injury already contracted under the preceding policy period.

Signature of policyholder _____

Date : _____

Please note the following

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

- > Copy of the previous years policy schedule (s) issued by the previous insurer or Renewal Notice (We shall provide portability benefits to the extent of documentary proofs provided / made available by you and subject to confirmation from your existing insurer).
- > Self-declaration by customer regarding no claims made
- > Proposal Form duly filled and signed in all respects including the details previous and existing health insurance
- > If there is a claim in existing policy, details of claims under the existing and previous policies and if so discharge summary, investigation and follow up report copies
- > Any other document that may be desired by the insurer