

PORTABILITY FORM

PART I

- 1) Name of the Policyholder / insured (s) _____
- 2) Date of Birth / Age _____
- 3) Address of policyholder / insured _____
- 4) Details of existing insurer
 - i. Name of the product _____
 - ii. Sum Insured _____
 - iii. Cumulative Bonus _____
 - iv. Add ons/Riders taken _____
 - v. Policy Number _____
- 5) Details of the proposed insurance
 - i. Name of the product proposed/intended to take _____
 - ii. Sum insured proposed _____
 - iii. Whether Cumulative Bonus to be converted to an enhanced sum insured _____
- 6) Reason (s) of portability _____
- 7) No of family member to be included in the policy to be ported _____

First Name of Insured	Details of Previous Health Insurance Policy / Policy No.	Health ID Card number	Sum Insured	CB	Period of Insurance		First Policy inception date
					From dd/mm/yyyy	To dd/mm/yyyy	

Enclosure: Photocopy of the existing policy documents

Date

D	D	M	M	Y	Y	Y	Y
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Signature of Proposer

PART II

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than existing policy Yes / No
 (Please indicate Yes /No)

2. If yes , please give written consent to the declaration below:

"I am aware that the waiting period for the following disease (s)/ treatment (s) isdays/years more than the previous policy terms, I hereby agree to observe the additional waiting period for the following diseases (s)/ treatments (s)

Signature of Policyholder