Portability Form

Part I

To be filled in CAPITAL LETTERS only.

Personal Details

Name of the Policyholder/Insured(s) :
(First Name) (Last Name)

Address :

City :

State :

Pin Code :

Landline : -

Mobile :

E-mail :

Date of Birth : / / (DD/MM/YYYY)

Age (in years/months) : (YY/MM)

Group Policy Details

Employee ID :

Name of the Company :

Details of the Existing Insurer

Name of the Insurer :

Name of the Product :

Add-on/Riders Taken :

Policy No. :

Details of the Existing Insurance Policy/Insured

Insured Name	Member ID	Date of Birth	Date of First Enrollment	Sum Insured	Cumulative Bonus

Details of the Proposed Insurance

Name of the product proposed/intend to take : _____

Sum Insured proposed : _____

Whether cumulative bonus to be converted to an enhanced sum insured ? ☐ Yes ☐ No

Reason(s) for portability : _____

No. of family members to be included in the policy to be ported : _____

Date : / / Signature of the Policyholder : _____

Part II

Whether the PED exclusions/time bound exclusions have longer exclusion period than the existing policy? ☐ Yes ☐ No

If yes, please give a 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 policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s)".

Signature of the policyholder : _____

Please Note the following :

For availing portability benefits kindly submit following documents in addition to portability form duly filled and signed.

1. Copy of the Last year Policy Schedule issued by the previous Insurer
2. Self-declaration by customer regarding no claims made.
3. If there is a claim in existing policy, then discharge summary, investigation and follow up report copies.
4. Renewal Notice

No Claim Declaration

I wish to apply for the "CARE" plan with your company under portability and declare that the rate of No Claim Bonus/Cumulative Bonus (NCB) stated by me is correct and that no claim has arisen in the expiring policy (copy of the policy and the renewal notice enclosed).

Religare Health Insurance Company Limited will seek confirmation of above stated details from my previous insurer. Pending receipt of the necessary confirmation from the previous insurer, Religare Health Insurance may issue the policy to me. Post issuance of the policy, if the information provided under this declaration is found to be incorrect, the policy issued to me shall be cancelled ab-initio and all premium under the policy will stand forfeited.

Date : | | / | | / | | | | Signature of the Policyholder : _____

Previous Policy Claim Details

Name of the Insured for whom claim was taken : | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Year of claim and nature/ details of illness : | | / | | / | | | | _____

_____

Claim Amount : | | | | | | | | | | | |

Name of the insurance company : from where claim was taken/filed | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Date : | | / | | / | | | | Signature of the Policyholder : _____

Note : Request you to provide discharge summary for each of the case included above.