IFFCO-TOKIO GENERAL INSURANCE CO. LTD.
Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

Website: www.iffcotokio.co.in

Toll Free No.18001035499

PROPOSAL FORM
HEALTH PROTECTOR / FAMILY HEALTH PROTECTOR POLICY

1. PROPOSER DETAIL

Proposer : Mr./Ms./Mrs.	F	I	R	S	T		N	A	M	E		M	I	D	D	L	E				L	A	S	T		N	A	M	E			
S/o, W/o, D/o, U/g	F	I	R	S	T		N	A	M	E		M	I	D	D	L	E				L	A	S	T		N	A	M	E			
Address :	H	N	O					S	T	R	E	E	T	/	C	O	L	O	N	Y												
	L	A	N	D		M	A	R	K																							
												City/Town :																				
District :												State :																				
Pin Code:												Mobile :																				
Telephone :												Emergency Contact Person :																				
Emergency Contact No :												E Mail :																				

Nationality : ☐☐☐☐☐☐☐☐ Qualification ☐

Marital Status : Single ☐ Married ☐ Widow ☐ Divorced ☐

Occupation Type : Salaried ☐ Business ☐ Practicing Professional ☐ Others ☐

Occupation Description : ☐ Gross Monthly Income Rs. ☐☐☐☐☐☐☐

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2. KYC Details (Please attach self attested photo copies)

PAN No.: ☐☐☐☐☐☐☐☐☐☐ UID / Aadhar No. : ☐☐☐☐☐☐☐☐☐☐☐☐

Passport / Driving Licence / Voter ID / Others: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3. Policy / Plan:

a. Health Protector (HP) ☐ b. Family Health Protector (FHP) ☐

4. Add on Cover

Critical Illness Cover Yes ☐ NO ☐

5. Do you want to opt for waiver of Room /ICU Rent limit (item 1(b) of 'What is Covered' as mentioned under Policy wording) on additional payment of 6% of basic premium? Yes ☐ NO ☐

6. **Nomination**: In the event of death of the proposer any payment due under the policy shall become payable to the nominee proposed in this form and the receipt of the proceeds by such nominee would be sufficient discharge to the Company. Nominee for all other persons proposed to be insured shall be the proposer himself/herself. The following section is to be filled by the proposer:

Nominee Name	Relationship	Address and Contact details of Nominee	%

7. Proposed Period of Insurance: From_____ To_____

(Subject to acceptance of proposal by Insurer and payment of premium before commencement of Risk)

8. Business Type:-- Fresh ☐ ITGI Renewal ☐ Transfer from Other Insurer ☐

9. If it is ITGI Renewal, Whether there is enhancement of Sum Insured----Yes ☐ No ☐

10. Details of the persons to be insured :

* For Floater Policy mention sum insured against the main member only

S.No	Name of Insured Person	Height (inch)	Weight (KGs)	Date of Birth (dd/mm/yy)	Gender (M/F)	Occupation	Relationship with the Insured	Sum Insured *	Fresh / ITGI Renewal / Portability	No of years of past continuous Policy

11. Details of present/previous medical insurance like Individual or Group Mediclaim, Cancer Policy, Critical Illness or any other Policy for any of the Insured Person. (Please use additional sheets if required)

S. No.	Name of Insured Person	Policy No.	Type of Policy (Group/Retail/ Others)	Name and address of Insurance Co.	Sum Insured	Period of Insurance		Cumulative Bonus, if any	Do you want to merge Cumulative bonus with Sum Insured (Y/N)
						From	To		
1									
2									
3									
4									
5									
6									

Note: Please attach a photocopy of the expiring Policy or current Renewal Notice for Portability

12. Details of Insurance claims lodged in the past. (Please use additional sheets if required)

S. No.	Name of Insured Person	Policy No	Date of claim	Nature and Description of claim	Amount of claim

13. Medical History: Please tick against the relevant insured if the answer is YES:

Section A : Have any of the persons proposed to be insured ever suffered from/ are currently suffering from any of the following :	Insured Person				
	1	2	3	4	5
i. High or low blood pressure					
ii. Diabetes					
iii. Chest pain, Ischemic heart disease or any other Heart disorder, Valve Related Disorder					
iv. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint like ligament/meniscus tear etc					
v. DUB, Fibroid, Cyst/Fibroadenoma or any other Gynaecological/Breast disorder					
vi. Asthma / COPD or any other lung/Breathing disorder					
vii. Tuberculosis					
viii. Ulcer (stomach/duodenal), hepatitis, cirrhosis or any other Digestive or Liver/Gallbladder Disorder					
ix. Renal failure, Kidney /ureteric stone or any other Kidney/Urinary tract or Prostate disorder					
x. Dizziness, Stroke, Epilepsy(fits) , Paralysis or other brain/ nervous system disorder/ Multiple Sclerosis					
xi. Thyroid disorder or any other endocrine disorder					
xii. Tumor-benign or malignant, any ulcer/growth/cyst /mass or cancer					
xiii. Diseases of the Nose/Ear/Throat/Teeth/ Eye (please mention Diopters for refractive errors					
xiv. HIV/AIDS or sexually transmitted diseases or any immune system disorder					
xv. Anaemia, Leukaemia or any other blood/lymphatic system disorder					
xvi. Psychiatric/Mental illnesses or Sleep disorder					
xvii. Any Congenital / Genetic disorders					
xviii. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending					
xix. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years					
xx. Been under any regular medication (self/ prescribed)					
xxi. Any other ailment / injury / sickness for which underwent treatment or undergoing /contemplating					
xxii. Any type of organ transplanted					

Section B : RISK FACTORS					
i. Do you Smoke?					
if Yes, Number of cigarettes / day					
For how many years					
ii. Do you consume Alcohol?					
if Yes, Quantity per week (in ml)					
For how many years					
iii. Do you have the habit of chewing tobacco / Gutka etc					
if Yes, Quantity per week					
For how many years					
iv. Family history of Hypertension / diabetes / heart attack (if Yes Please provide details below)					

Sl. No.	Relationship	Details

14. If your answer is **YES**, to any of the questions above, please provide details in the Table given below (Please use additional sheets if required)

S. No.	Name of Insured Person	Name of disease/injury	Treatment/medication received /receiving	Name of the Treating Doctor	Since When	Whether fully cured?

15. Whether any Insurance company (including IFFCO Tokio) has declined to accept the proposal of any of the members earlier? If Yes, please provide details.

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16. Any additional facts which affect the proposed insurance & should be disclosed to the insurer.

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17. PAYMENT DETAILS: Please fill in your payment details: Cheque ☐ DD ☐ Credit Card ☐ Debit Card ☐ Cash ☐

Amount in figures ☐☐☐☐☐☐ Amount in words________________________________

Bank Name__________________Branch__________________City___________Cheque /DD No. ☐☐☐☐☐☐

Cheque/DD Date: ☐☐☐☐☐☐ Name of the Payer__________________________Relation to Proposer____________

Credit/Debit Card Type: Master ☐ Visa ☐ American Express ☐ Others ☐

Credit/Debit Card No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Card Holder Name:________________________

Expiry Date: DD/MM/YY: ☐☐ ☐☐ ☐☐ CVV No. ☐☐☐☐

18. BANK DETAILS TO RECEIVE PAYMENT FROM INSURER:
Payee Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account No. ____IFSC/NEFT/RTGS Code: ___________________

Bank Name: _____________________________________Branch Address_______________________________

DECLARATION

1. "I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.
2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.
3. I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority."

I, hereby declare and warrant that the above statements are true and complete. I agree that this proposal shall form the basis of the contract should the insurance be effected. If after the insurance is affected, it is found that the statements, answers or particulars stated in the proposal form and its questionnaires are incorrect or untrue in any respect, the insurance company shall incur no liability under this insurance.

I have read the prospectus/sales literature and am willing to accept the coverage subject to the terms, conditions and exceptions prescribed by the insurance company therein. The policy Coverage and exclusions, Rates, terms & Conditions have been explained to me in my language and have been understood by me

Date Signature of Proposer: Signature of the witness

Place: Name of Proposer: Name and address of the witness

Note:

- Please fill in the proposal for carefully and answer all the questions honestly.
- **Please do not leave any question blank or write "-". This will only be construed as a "No" or "NIL" (or similar) declaration from the Insured**
- **Incorrect or non-disclosure of facts will make the contract void and all the benefits under the policy including the premium paid shall be forfeited.**
- People above **the specified** age should submit the prescribed test reports also along with proposal form. Please check with your agent for the details.
- Insurance Company reserves the right to seek additional information, diagnostic reports, Certificate from a doctor etc any time before the acceptance of the proposal / inception of cover.
- Company will reimburse 50% of the cost of prescribed tests, subject to a maximum of Rs. 750/- in case the proposal is accepted.
- Acceptance of the proposal is purely at the discretion of Insurance Company.
- Insurance company may accept the proposal at revised terms and / or rates. In such case the Insured reserves the right to decline before commencement of policy.
- Insured has a free-look period of 15 days from the inception of the policy subject to the guidelines of IRDA
- Submission of this proposal does not entail the proposer any rights. The liability of the insurer commences only after the proposal is accepted by the Insurer, payment of premium before commencement of risk and/or the date of inception of risk mentioned in the policy (whichever is later)

SECTION 41 OF THE INSURANCE ACT 1938

PROHIBITION OF REBATES

Payment of rebates is expressly prohibited under Section 41 of the Insurance Act, 1938.

1. No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind or risk relating to lives or property in India any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy nor shall any person taking out or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the Insurer.

2. Any person making default in complying with the provisions of this Section shall be punishable with fine, which may extend to Rs.500/-

Agent's declaration

I, _____(Full Name) in the capacity of Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained (in vernacular/local language as well) to the proposer all the contents of this Proposal Form including the nature of the question(s), statement(s), information and response(s) submitted by him/her. Any detail submitted through this proposal form will be considered as the basis of the Contract of Insurance between the Insurer and the Proposer, subject to the acceptance of the proposal. I have further explained that in case of any untrue statement(s)/information/misrepresentation is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to reject the proposal or limit benefits under the policy at its sole discretion. Also, in case of non-disclosure of any material fact, the policy issued to his/her favour based on the Proposal form may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited by the company.

Signature of the Advisor/Corporate Agent/Broker/Relationship Officer)
License No. and Agency Code/Broker Code/ Employee No. _____
Date:

For Office Use Only **SBU/LSC/BIMA KENDRA CODE: _____**

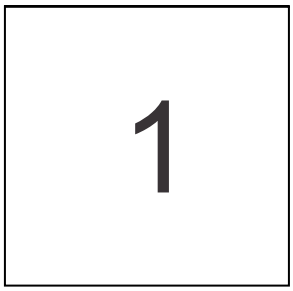
Checklist for Underwriter:

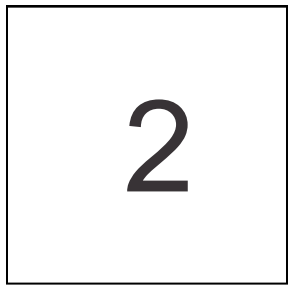
1. Date of Acceptance: _____
2. Medical Reports attached Yes / No No of Reports ( )
3. Approving Authority : SBU/ Regional Office/ Corporate Office
4. Approval /E-mail Approval attached Yes / No Date of Approval _____

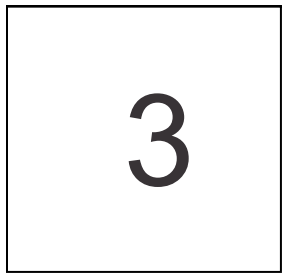
Name of the Accepting Officer: Signature of the Accepting Officer

Photographs:

Name 1._____ **2.**_____ **3.** _____







Name 4._____ **5.**_____ **6.** _____