GENERALI Central INSURANCE

IO No	
App No	
Client Code	
Receipt No	
Payer ID	
SB/CA Acc No	
Journal no/ Bank name	

PROPOSAL FORM FOR HEALTH TOTAL

Important guidelines:

1. *Insurance is the contract of utmost good faith requiring of the proposer and the insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form.*
2. *Please answer all questions carefully. Any incomplete, incorrect or partially correct answers may lead to rejection of the proposal and might lead to cancelation of policy.*
3. *It is important to fill all questions, information for fields marked with asterisk [*] ismandatory.*
4. *Cover shall commence not earlier than the date and the time of acceptance and subsequent to payment of the premium.*

Received date:_____ **Branch code:**_____ **Branch name:**_____

Period of insurance desired: from: DD / MM / YYYY **to** DD / MM / YYYY

Proposer details*: Name Mr. ☐ Ms. ☐ M/s ☐

Permanent address and Other Details:

Present address (If same as above, please tick here) ☐

State	**Pin code**
Tel No*	**Mobile no***
Email id*	
PAN	***Note**: PAN is mandatory where the premium exceeds Rs. 50,000/- in cash and where premium exceeds Rs. One Lakh in any mode.*
e-IA Number (e-Insurance Account Number)	*If not available request, you to kindly download the form from our website and request you to kindly submit along with this proposal form*

3. **Gender*:** ☐ Male ☐ Female ☐ Third Gender
4. **Date of birth*:** / /
5. **Age*:**_____
6. **Nationality*:**_____
7. **Annual gross income (₹) :**_____
8. **Marital status*:** ☐ **Married** ☐ **Single** ☐ **Widow** ☐ **Divorce** ☐ **Live-in relationship**
9. **Occupation*** ☐ **Service** ☐ **Self-employed** ☐ **Other**

10. Family **doctor details: Dr.**	
Address	Telephone
State	Pin code
Email id	Fax NO

11. Are you an existing Generali central insurance company *? ☐ Yes / ☐ No. If yes, please provide:
Existing policy no:_____ Customer id no: _____

12. If you are Differently Abled, please tick mark on the checkbox to provide confirmation? ☐
If yes, kindly provide the below details

Type of Impairment :

Percentage of Impairment :

UDID Number :

13. Plan details*: (please refer to the brochure for details of the plan before choosing the plan)
Options: Individual (in case sum insured opted on individual basis kindly fill details in table number 16 below)
Floater (in case sum insured opted on floater basis kindly tick the required plan below)

	Plans		
Vital	₹ 300,000	₹ 500,000	₹ 1,000,000
Superior	₹ 1,500,000	₹ 2,000,000	₹ 2,500,000
Premiere	₹ 5,000,000		₹ 10000000

14. Voluntary deductible:
Deductible amount in ₹ Per claim (please tick any one deductible as per the plan opted)
Discount in % in lieu of voluntary deductible

Options		A	B	C
Vital plan	Deductible	☐ ₹ 10,000	☐ ₹ 25,000	☐ ₹ 50,000
	Discount	10.00%	15.00%	20.00%
Superior plan	Deductible	☐ ₹ 50,000	☐ ₹ 75,000	☐ ₹ 1,00,000
	Discount	15.00%	20.00%	25.00%
Premiere plan	Deductible	☐ ₹ 1,00,000	☐ ₹ 2,50,000	☐ ₹ 5,00,000
	Discount	15.00%	20.00%	25.00%

15. Policy term *(please tick the term opted): ☐ 1 year ☐2 years ☐3 years
In case policy term more than one year, installment option is available. Please tick any one option in case you want to opt for: ☐ Monthly ☐ Quarterly ☐ Half yearly
Please Note: Under installment option, for policies issued from 1st to 15th of the month, 5th of month shall be the Automated Clearing House (ACH) debit date. For policies issued from 16th to 31st of the month, 25th of the month shall be the ACH debit date.

16. Family definition:
- **Vital plan:** - Family means - self, spouse/Live-in partner, dependent children (unmarried and up to the age of 25 years) and dependent parents
- **Superior plan & Premiere plan:** Family means-self, spouse/Live-in partner, dependent (unmarried and up to the age of 25 yrs) or non – dependent children, dependent or non – dependent parents, dependent siblings, daughter in law, son in law, parents in law, grandparents and grandchildren

Note - any of the above plans can be opted either on individual basis or on floater basis.
*For Individual and Family Floater cover kindly indicate details of all the members to be covered as per the table below.
*Please note for Family Floater cover do not fill anything in sum insured & premium computation column since sum insured and Voluntary deductible option (if opted) is common for all members.

17. Details of persons to be insured* (in case the nominee is a minor, please provide the name of the appointee)**

Sr. No	Name	Gender	Date of birth	ABHA No^^	Relationship with proposer	Height	Weight	Occupation	Plan & sum insured/ Voluntary Deductible opted	Premium computation individual or floater (for office use only)
1	Primary insured				Self					
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

^^Please provide ABHA number (Ayushman Bharat Health Account number) for all the proposed Insured Persons. In case the ABHA number is not available for any Insured Person, you may request to create an ABHA number by visiting the web link: https://healthid.ndhm.gov.in/register

18. NOMINEE DETAILS

In case the Policyholder (Presently, proposer) dies, payments due under the policy that may be issued shall be payable to the credit of the nominees identified through this proposal. Nominee(s) for the proposal shall, preferably, be an immediate relative of the Proposer. Vide insurable interest of the proposer in the other persons proposed to be insured, the proposer is construed as nominee for such other persons, unless differently advised.

Sr No	Particulars	Nominee 1	Nominee 2	Nominee 3	Nominee 4
1	Name				
2	Age				

3	Mobile No.				
4	Email ID				
5	Present Address				
6	Permanent Address (If same as above, please tick here) ☐				
7	Relationship with the Proposer				
8	Specify the Percentage (%) of Claim amount payable to each nominee in the event of the policyholder's death. The total percentage of contribution across all the nominee(s) must not exceed 100%				
9	Bank details of the nominee				
a.	Account No.				
b.	IFSC/MICR Code				
c.	Name of the Bank				
d.	Account Holder Name				
Appointee Details (Required only if the nominee is a minor)					
Sr No	Particulars	Appointee 1	Appointee 2	Appointee 3	Appointee 4
1	Name				
2	Age				
3	Mobile No.				
4	Email ID				
5	Present Address				
6	Permanent Address (If same as above, please tick here) ☐				
7	Relationship with Appointee				
8	Specify the Percentage (%) of Claim amount payable to each nominee in the event of the policyholder's death. The total percentage of contribution across all the nominee(s) must not exceed 100%				
9	Bank details of the Appointee				
a.	Account No.				
b.	IFSC/MICR Code				
c.	Name of the Bank				
d.	Account Holder Name				

19. Section applicable for females only pregnant

a. Please confirm if any of the persons to be insured is Pregnant ☐ Yes / ☐ No

b. Please indicate obstetric details in below table for all femalesinsured:

Sr. No	Insured name	Number of living children as on date	Any maternity related complications in present or past , For example miscarriage, gestational diabetes, ectopic pregnancy or any other, please provide details

20. Health questions*: please answer "Yes" or "No". If "Yes" please provide details below.

Sr no	A	B	C	D	E	F	G
	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity?	Do you regularly consume tobacco / alcohol or smoke - (please specify – yes/ no. If yes please mention – quantity / day, number of years since consuming/ smoking)	Does any person to be insured suffer or has suffered in the past from any of the following? Disorder of the heart including ischemic heart disease / rheumatic heart disease, or circulatory system, chest pain, high blood pressure, stroke, asthma, any respiratory condition, cancer or tumor / lump of any kind, diabetes, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychiatric conditions, any disease of brain or nervous system, fits (epilepsy), slipped disc, backache, any congenital / birth defects / disease, AIDS or tested positive for HIV, or any other disease – yes / no. If "yes", indicate in the table given below.	Name of disease / illness / injury suffering from, in the past or at present. Any other diseases or ailments not mentioned? If "yes", give details in the table given below.	Disease / illness / injury / suffering since when / when first treated (applicable to question 21-c and d both). If applicable please mention details. If not applicable please mention "no" in the table given below	Treatment / Medication received / receiving. If applicable please mention details. If not applicable please mention "no" in the table given below	Are you fully cured? (Yes /No) – applicable only if any of the points "c" to "f" is "Yes"
Insured 1	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 2	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 3	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 4	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 5	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 6	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 7	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 8	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 9	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 10	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 11	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 12	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 13	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 14	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 15	Yes/no	Yes/no	Yes/no	Yes/no			

21. Other concurrent health insurance information*(please provide details of any health insurance cover that you or your family members hold for Generali Central Insurance Company Limited. Limited Or any other healthinsurance)

Description	Policy no	Name & address of insurance company	Sum insured	Period of insurance (first inception date -dd/mm/yy)	From: dd/mm/yy to: dd/mm/yy	Claim details, claim amount received or receivable (in Rs)

Insured 1						
Insured 2						
Insured 3						
Insured 4						
Insured 5						
Insured 6						
Insured 7						
Insured 8						
Insured 9						
Insured 10						
Insured 11						
Insured 12						
Insured 13						
Insured 14						
Insured 15						

22. In case of portability/ migration, kindly fill portability/ migration request form along with this form.

23. Attach age proof document for each insured. Please tick whichever is applicable:

☐ Passport ☐ PAN Card ☐ Driving license ☐ Letter from recognized public authority
☐ School/college leaving certificate ☐ Others, please specify.

24. Payment Details

Instalment Details: If you want to opt for premium payment in instalment option, please tick the required from the below options

Instalment Frequency : Monthly ☐ Quarterly ☐ Half Yearly ☐ Annually ☐

E-mandate/E-NACH* ☐ Please provide the Bank Name:

*Link will be sent to registered mobile number mentioned in the Proposal Form for activating E-mandate/E-NACH. If the same is not activated, the subsequent instalment will not be auto-debited and risk will not be covered.

The updated list of eligible Banks for E-mandate/E-NACH is available under National Payments Corporation of India (NPCI) website https://www.npci.org.in/

Payment Option : Cheque ☐ Demand Draft ☐ Fund Transfer ☐ Pay Order ☐ Debit Card ☐
Credit Card ☐ Others (please specify) ☐ _____

Premium Amount : ₹_____ Amount in Words: _____

Account Holder Name :

Instrument Number : Instrument Date :

Transaction ID (for online payments) : Bank Name :

Bank Details (required for direct payment of claims/ refunds in the account):

Name of the account holder:

Name of the bank:

Branch:

Account no.:

Bank IFSC code: MICR:

Account Type: ☐ Savings ☐ Current ☐ Others (please specify) _____

Please fill up the request for authorisation form attached with this Proposal Form to receive Claim / Refund Payments, if any, directly into your bank account through NEFT. It is necessary where the premium is more than ₹ 10,000/-.

25. True to our Go Green initiative, we will send the digitally signed and authenticated policy document to your e-mail address, as you've mentioned in this proposal, and you may download and save a copy of it. If you still wish for a physical copy, you may tick on this box Yes ☐ No ☐

26. DECLARATION

1. I 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 am authorised 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 insurer and that the policy will come into force only after full payment of the premium chargeable.
3. I further declare that I 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 declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.
6. I, further, declare and warrant that:
   - There is no other material/relevant information, that has not been disclosed to GCICL and if any information given in this proposal is found to be untrue, the insurance policy shall be void ab initio and the premium shall be forfeited to GCICL.
   - Service related information from GCICL, and its service providers, through electronic and telecom modes, including WhatsApp, can be sent to me and understand that no unsolicited information will be sent to me.
   - the information/data provided by me, through this application, to GCICL and/ or GCICL authorised person/ agency, shall be stored by GCICL, throughout the currency of my relationship with GCICL, and used for the purposes relating to my proposal for insurance cover and/or servicing policies issued in my favour, whether by GCICL or its authorized partners. I also understand that the said storage is necessary for my consumption of the services and consent to not hold GCICL and/or its authorized partners/ agency/ person liable for legitimate utilization of the submitted information/data.

7. I declare that the premium amount, corresponding to this proposal, is paid out of the legally declared and assessed sources of my income and not out of proceeds of crime related to any offence under the Prevention of Money Laundering Act, 2002 and rules framed thereunder. I understand that GCICL reserves the right to call for documents and information to establish the source of funds, as also the right to reject the said proposal or to terminate the insurance contract unilaterally and/or forfeit the premium amount, if I am found to be named in any recognized sanction list/happen to have violated any provisions of law. ORI confirm that the premium has been paid by _____, who has an insurable interest in my policy and refund, if any, shall be processed in my bank account.
8. I am (please tick all that are applicable) □ HNI □ NRI □ Politically Exposed Person □ Jeweller □ NGO □ Film Actor □ Producer □ Others.
   If you are an NPO/NGO, please provide Niti Aayog – Darpan Portal registration number_____
   ^Non-profit organization means any entity or organization, constituted for religious or charitable purposes referred to in clause (15) of section 2 of the Income-tax Act, 1961, that is registered as a trust or a society under the Societies Registration Act, 1860 or any similar State legislation or a Company registered under the section 8 of the Companies Act, 2013.
9. ABHA Declaration (Applicable only if you have shared the ABHA number with Us) - I, hereby declare that I am voluntarily sharing Ayushman Bharat Health Account number (ABHA No) for the proposed Insured Persons, with Generali central insurance company Limited, for the sole purpose of accessing my records of medical history, which will be used to verify/share relevant information provided herein on confidential basis within its Group and /or third party agencies in connection with the Claims, for the purpose of facilitating insurance/ reinsurance services and ancillary services
10. I agree that the information/data, contained in this proposal, shall be processed for purposes related to this proposal and the insurance policy that may be issued hereon. I understand that all such information/data will be handled as per the GCICL Privacy Policy, available at https://generalicentralinsurance.com/privacy-policy
11. I consent to the fact that GCICL may download my/proposer's CKYC record from the Central KYC Records Registry, in relation to the verification of my/proposer's KYC records as part of this proposal. I understand that acceptable officially valid documents shall be relied upon for the said verification of KYC records. I, also, consent to receive information from the Central KYC Registry through SMS/email on the abovementioned mobile phone number/email address.
    It is, also, confirmed that the KYC records available in the CKYC Registry are current and valid, as on the date of this proposal, and can be used by GCICL hereafter. In case of any modification, the applicable information will be provided to GCICL for updating the CKYC Registry Records.
12. **Bima – ASBA Declaration (*Please tick the box if you want to utilize the Bima-ASBA facility*)**
    ☐ I hereby accord my consent to authorize Generali central Insurance Company Limited to block the applicable premium payable for the aforesaid insurance policy under the BIMA ASBA facility and debit the same from my bank account upon acceptance of this proposal. In case the proposal is not accepted, I accord my consent to debit only the expenses incurred towards medical examination, if any, and unblock the balance amount"

Optional Declaration

I/We hereby give my/our consent to the Company to use my/our personal information for quality and data analysis purpose which may be carried out by an empaneled third party vendors □ Yes / □ No

*Note: I hereby acknowledge that I have read and understood the contents of the prospectus and have been explained the features, contents and terms of the * Prospectus/ Product by the Intermediary/Agent to my/our satisfaction (*To download a copy of the Prospectus and for further details about the product, please visit our website https://generalicentralinsurance.com/customer-service/downloads)*

Date: DD / MM / YYYY Place: Proposer's Name: Proposer's Signature/ Thumb Impression:

For use by Intermediary Only

I, _____, in my capacity as an Insurance Agent/POSP/Specified Person of the Corporate Agent/Authorized Person of the Broker/IMF, declare that I have explained the product features, including its suitability, and the contents of this proposal form, including the nature of the questions and the responses submitted thereto, to the proposer. It has been, further, informed to the proposer that the details provided herein shall form the basis of the contract of insurance between GCICL and the proposer. It has, also, been explained that if any untrue response(s) is/are contained in this proposal form or there has been any non-disclosure of material facts, the policy issued thereon shall, at the option of GCICL, be treated as null and void and the premium amount against the policy may be forfeited by GCICL.

Vernacular declaration

I hereby confirm that the product features and terms of the above product have been explained to the prospect in detail (including product suitability) and to the prospects' complete satisfaction. (In case prospect signs in a language other than English/or is not literate)

**Applicable only when proposer has signed in thumb impression and is witnessed by someone other than agent/ employee of the company.*
I hereby declare that, I have clearly explained the content of this form to the proposer there after the proposer has affixed the thumb impression above after fully understanding the content thereof.

Witness Name:	Intermediary / Agent Name:
Witness Signature:	Intermediary / Agent signature:
POSP Name:	POSP Code:
POSP PAN No.:	
Date and Place:	

DECLARATION BY AUTHORIZED REPRESENTATIVE OR PERSON WITH DISABILITY

I, Mr./Ms._____, authorize Mr./Ms. _____ as my authorized representative to act on my behalf, and for all the persons proposed to be insured, in all matters related to this health insurance proposal, including but not limited to:

a) Discussing and obtaining relevant information regarding the health insurance coverage, benefits, features and claims;
b) Providing personal and medical information required for completion and processing of this proposal;
c) Taking decisions regarding my application/ proposal, claims, servicing requirement and discharge processes, related to the health insurance policy that GCICL may issue;
d) Coordinate with designated service providers engaged with/by GCICL for administration of the insurance cover; and
e) Signing necessary documents in relation to this health insurance proposal and any other decisions relating to/arising therefrom.

Signature of Proposer :
Name of Authorized Representative : Relationship with the Proposer :
Address : Contact No :
Signature of the Authorized Representative :
Date :
Name of Witness : Signature of Witness :
Date : Place :

OR

I, Mr./Ms._____, have been authorized by Mr./Ms. _____, as their representative to act on their behalf in all matters related to this health insurance proposal, including but not limited to:

a) Discussing and obtaining relevant information regarding the health insurance coverage, benefits, features and claims;
b) Providing personal and medical information required for completion and processing of this proposal;
c) Taking decisions regarding my application/proposal, claims, servicing requirement and discharge processes, related to the health insurance policy that GCICL may issue;
d) Coordinate with designated service providers engaged with/by GCICL for administration of the insurance cover; and
e) Signing necessary documents in relation to this health insurance proposal and any other decisions relating to/arising therefrom.

Name of Authorized Representative : Relationship with the Proposer :
Address: Contact No :
Signature of the Authorized Representative : Date :
Name of Witness : Signature of Witness :
Date : Place :

SECTION 41. OF INSURANCE ACT, 1938-PROHIBITION OF REBATES

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 of risk relating to lives or property in India, any rebate of whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to Ten Lakh Rupees.