IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

PROPOSAL FORM

SWASTHYA KAVACH POLICY

1. Name of the Insured : Mr/Ms

2. Address :

3. Telephone/Mobile :

4. E-mail :

5. Nationality :

6. Income Tax PAN No. :

7. Name and address of the Family Doctor :

8. Telephone :

9. Qualification :

10. Plan : Base Plan ☐ Wider Plan ☐

11. Sum Insured : Rs._____/-

12. Details of the persons to be insured :

S.No.	Name of Insured Person	Height	Weight	Date of Birth	Gender	Occupation	Relationship with the Insured

13. 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

Note: A photocopy of the expiring Policy or current Renewal Notice is necessary for transfer of Cumulative Bonus, if any.

Name of Insured Person	Policy No.	Name and address of Insurance Co.	Sum Insured	Period of Insurance

14. Details of claims lodged under such Policies during the last 4 years .

S. No.	Name of Insured Person	Date of claim	Nature of claim	Amount of claim

15. Do you require the benefit of additional Sum Insured for Critical Illness* available as higher sum insured on payment of additional premium under the Policy? Please note that this option is available on floater basis on all or none basis for the Insured Persons under the Policy.

Yes ☐ No ☐

*__Critical Illness consists of following diseases__:

a) Cancer Of Specified Severity
b) First Heart Attack - Of Specified Severity
c) Open Chest CABG
d) Open Heart Replacement or Repair Of Heart Valves.
e) Coma of Specified Severity
f) Kidney Failure Requiring Regular Dialysis
g) Stroke Resulting In Permanent Symptoms
h) Major Organ /Bone Marrow Transplant
i) Permanent Paralysis Of Limbs
j) Motor Neurone Disease with Permanent Symptoms
k) Multiple Sclerosis With Persisting Symptoms
l) Major Burns
m) Major Injuries
n) End stage Liver Disease

(Detailed definitions are given in the Policy document)

16. Is any of the persons proposed for insurance receiving any treatment/ medication or has in past four years received treatment for any medical condition or disability?
If YES, indicate details in the Table given below

S. No.	Name of Insured Person	Name of disease/injury suffering from	Treatment/medication received /receiving	Date first treated	Whether fully cured?

17. Medical History: Please answer the below mentioned questions Yes or No only:

	Insured Person 1	Insured Person 2	Insured Person 3
Section A : Have any of the persons proposed to be insured ever suffered from/ are currently suffering from any of the following :			
i. Hypertension, chest pain, Ischemic heart disease or any other cardiac disorder			
ii. Tuberculosis, asthma, bronchitis or any other lung/respiratory disorder			
iii. Ulcer (stomach/duodenal), hepatitis, cirrhosis or any other Digestive or Liver/ Gallbladder disorder			
iv. Renal failure, calculus or any other Kidney/Urinary tract or Prostate disorder			
v. Dizziness, Stroke, Epilepsy, Paralysis or other brain/ nervous system disorder			
vi. Diabetes, Thyroid disorder or any other endocrine disorder			
vii. Tumor-benign or malignant, any ulcer/growth/cyst			
viii. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint			
ix. Diseases of the Nose/Ear/Throat/Teeth/ Eye (please mention Diopters)			
x. HIV/AIDS or sexually transmitted diseases or any immune system disorder			
xi. Anaemia, Leukaemia or any other blood/lymphatic system disorder			
xii. Psychiatric/Mental illnesses or Sleep disorder			
xiii. DUB, Fibroid, Cyst/Fibroadenoma or any other Gynaecological/Breast disorder			
Section B : Have any of the persons proposed to be insured:			
xiv. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxification therapy			
xv. Been under any regular medication (self/ prescribed)			
xvi. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years			
xvii. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending			
xviii. Suffered from any other disease/illness/accident/injury			

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

17. If the proposal is a case of portability, then the additional proposal form relating to portability has also to be filled in (as per IRDA draft format).

18. **Nomination**: In the event of the 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 Of Nominee

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.

Date Signature of Insured:

Place: Name of Insured:

Note: If answer to the question 11/12 is "Yes" or if you have to declare ailments / processes in response under item 11,12 & 13 or if you are above 45 years of age, please submit the Medical Certificate in the prescribed format duly completed and signed by a Consulting Physician/ Surgeon along with the following test reports :ECG , Blood Sugar (PP, fasting and Urine), Urea and Creatinine.

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 my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.
License No. (Advisor/Corporate Agent/Broker/Relationship Officer)/Agency Code/Broker Code:

Date: Place : Signature of Agent

For Office Use Only

Checklist for Underwriter :

1. Medical Reports (if applicable)
2. Approving Authority : SBU/ Regional Office/ Corporate Office
3. Approval /E-mail Approval attached :

TO BE COMPLETED BY CONSULTING PHYSICIAN# /SURGEON

(Applicable for those with adverse medical history* and / or above 45 years of age)

1. **Name Of The Insured Person:**

2. **History**:

   a) Present Complaints and Investigation, if any :

   b) Any Past History Of Diseases, Operations, Accidents, Investigations With Date, Major Medical Complaints Or Hospitalisation:

   c) Details Of Present And Past Medication With Duration:

   d) Is He/She Cured Of Diseases, if any? When Was Your Treatment, if any:

3. **General Examination** :

Systematic Examination :

*** Reply to the questions 8 being "No" and Reply to question 9, 10 and/or 11 being "Yes"**

Signature of Proposer	Signature of Consulting Physician#
Date:	Name Of Consulting Physician
Place:	Qualifications#:
Address:	Tel. No.

 # Minimum qualification of Physician should be MBBS

To be completed by Official of Insurance Company

Do you consider the risk as acceptable? :

Competent Authority to accept the Proposal:

Name:

Signature: