FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Health PowHER Proposal Form

IO No/Win No.	:
App No	:
Client Code	:
Receipt No	:
Payer ID	:
SB / CA Account No	:
Journal No / Bank Name	:

Important Guidelines:

1) Insurance is a contract of utmost good faith. It requires of the proposer and the insured to not only disclose all material facts, but also to not suppress any material facts in response to the questions in this proposal form. It is highlighted that this proposal form is the basis of the policy contract, if and as may be issued hereon.
2) Please complete all sections in capital letters and tick the appropriate boxes, wherever applicable. It is mandatory to furnish all information for fields marked with an asterisk [*].
3) Failure to disclose facts material to the assessment of the risk or providing misleading/partial information may lead to rejection of this proposal / cancellation of the policy, if and as may be issued.
4) This proposal form shall have to be signed by the proposer.
5) We are under no obligation to accept any proposal for insurance. Our liability will commence only when this proposal is accepted by us. Our liability shall be subject to the terms and conditions mentioned in the policy schedule, as may be issued, and the corresponding policy wordings. Our liability will not arise unless the premium amount is received by us.

Receipt Date:	**Branch Name:**	**Branch Code:**

I. PROPOSER DETAILS

Proposer Name * : ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Mx.

Date of Birth* : D D M M Y Y Y Y Age (in years) :

Marital Status* : ☐ Married ☐ Single ☐ Widow / Widower ☐ Divorcee ☐ Live-in relation

Nationality* ☐ Indian ☐ NRI ☐ Others (please specify) :

Gender* : ☐ Male ☐ Female ☐ Third Gender E-mail Id* :

Occupation : ☐ Self Employed ☐ Salaried ☐ Homemaker ☐ Retired ☐ Others (please specify) :

PAN Number : (Mandatory where the premium exceeds Rs. 50,000/- in cash and where premium exceeds Rs. One Lakh in any mode)

Permanent Address* :

Landmark : City / Town :
District : Pin Code* :
Telephone No.* : Mobile No.* :

Present Address: (If same as above,

Landmark : City / Town :
District : Pin Code* :
Telephone No.* : Mobile No.* :

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please tick here) ☐

Are you an existing Future Generali Customer? * : ☐ Yes ☐ No

If yes, existing policy no. : Customer ID No. :

II. PLAN DETAILS – Please select the required Sum Insured

Note: Any of the Sum Insured can be opted either on Individual basis or on Family floater basis.

Policy Period * : ☐ 1 Year ☐ 2 Year ☐ 3 Year

Proposed Policy Period* : From : D D M M Y Y Y Y To : D D M M Y Y Y Y

Cover Type* : ☐ Individual ☐ Family Floater

Family Definition:

For individual policy *- Self, Live-in Partner/Spouse, Dependent Children (Max up to 4), Parents, Parents-in-law*

For Floater Policy *- Self, Live-in Partner/Spouse, Dependent Children (Max up to 4), Parents /Parents in law.*

In case, Sum Insured & Voluntary Co-payment to be opted on Family Floater basis, please tick on the appropriate plan, Sum Insured below table. In case of Sum Insured & Voluntary Co-payment on Individual basis, please fill table no. III

Plans	☐ Essential	☐ Advance	☐ Supreme
Base Cover Sum Insured	☐ ₹ 5,00,000	☐ ₹ 15,00,000	☐ ₹ 25,00,000
	☐ ₹ 10,00,000	☐ ₹ 20,00,000	☐ ₹ 50,00,000
			☐ ₹ 75,00,000
			☐ ₹ 10,000,000
Do you want to opt for Voluntary Co-payment? If yes, please tick on any one co-payment:	☐ 10% ☐ 20% ☐ 30%		

Critical Illness and Personal Accident Cover - The Sum Insured options are available on individual basis only. To opt for the optional cover, please fill the required Sum Insured under Optional Cover in table III. The Sum Insured options can only be selected as available under the specific Plan which should be same as the Base Cover Plan.

Plans	Essential	Advance	Supreme
Critical Illness & Personal Accident Cover	₹ 5,00,000	₹ 5,00,000	₹ 5,00,000
	₹ 10,00,000	₹ 10,00,000	₹ 10,00,000
		₹ 15,00,000	₹ 15,00,000
		₹ 20,00,000	₹ 20,00,000

III. PROPOSED INSURED DETAILS* (In case the number of persons to be insured is more than 6, please fill the attached Annexure)

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name						
Gender						
Date of Birth (DD/MM/YYYY)						
Marrital Status						
ABHA No^^						

Relationship with Proposer						
Height (Cm)						
Weight (Kg)						
Occupation						
Sum Insured (Base Cover)						
Optional Cover						
Critical Illness (For members aged between 18 to 65 years only)						
Personal Accident Cover (For members aged between 3 to 65 years only)						
Voluntary Co-payment?	☐ 10% ☐ 20% ☐ 30%					
Please attach age proof document for each insured. The below age proofs will be considered:						
Passport, PAN Card, Driving License, School/ College leaving certificate, Letter from recognized public authority.						

^^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.

IV. 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				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	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				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	Account Holder Name				

V. MEDICAL AND HEALTH INFORMATION* (In case the number of persons to be insured is more than 6, please fill the attached Annexure)						
Please answer below mentioned questions	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
1. Do you consume tobacco in any form?	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes

		☐ No	☐ No	☐ No	☐ No	☐ No	☐ No
	Type-Cigarette/ Beedi/ Cigar/ Gutkha/ Others						
	If you have stopped smoking – Since when	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY
2.	Do you consume alcohol in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Type – Beer/ Hard liquor/ Wine/ Others						
3.	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity? Yes ☐ No ☐						
	Has any person to be insured is currently suffering from/suffered in the past/taking treatment for any illness/disease or injury for following medical conditions? YES ☐ NO ☐ (If yes, please select the disease for the specific insured person)						
	a) Psychiatric/Mental/Sleep Disorder	☐	☐	☐	☐	☐	☐
	b) Stroke/Epilepsy/Paralysis or other brain / nervous system disorders	☐	☐	☐	☐	☐	☐
	c) Disease related to Ear/ Nose/ Throat	☐	☐	☐	☐	☐	☐
	d) Tuberculosis/Asthma or any lung / respiratory disorder	☐	☐	☐	☐	☐	☐
	e) Hypertension/ Chest pain/ heart disease	☐	☐	☐	☐	☐	☐
	f) Liver Disease/Ulcers (stomach/ duodenum)/ Gall stones/ Hepatitis/ other digestive Disorders	☐	☐	☐	☐	☐	☐
	g) Kidney Failure/Dialysis/Kidney Stones/ Prostate/ other kidney disorders	☐	☐	☐	☐	☐	☐
	h) HIV/AIDS/ Sexually Transmitted Disease	☐	☐	☐	☐	☐	☐
	i) Diabetes/ Thyroid or any other endocrine disorders	☐	☐	☐	☐	☐	☐
	j) Arthritis, Spondylitis, Joint Pain, Slip Disc, Spinal Disorder or any other disorder of muscle/ bone/ joint	☐	☐	☐	☐	☐	☐
	k) Cancer/Tumour- Benign or Malignant	☐	☐	☐	☐	☐	☐
	l) Anaemia or any other blood disorder	☐	☐	☐	☐	☐	☐
	m) Females Specific – Fibroid / Cyst/ Fibroadenoma/ Breast disorder or any other Gynaecological Disorder	☐	☐	☐	☐	☐	☐
	n) Any accidental injury that has caused disability / hospitalization	☐	☐	☐	☐	☐	☐
	o) Treatment for Infertility or has been advised for?	☐	☐	☐	☐	☐	☐

	p) Others (Please Specify with diagnosis)	☐	☐	☐	☐	☐	☐
4.	Is any of the female insured pregnant? If yes, please mention the expected date of delivery	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY

VI. ADDITIONAL INFORMATION (In case the number of persons to be insured is more than 6, please fill the attached Annexure)

If any of the proposed insured person is suffering from/suffered in the past/taking treatment for any illness/disease or injury and the same is declared in above Section -V.3, then please provide further details

Insured Name	Name of Illness/ Surgery	Date of first diagnosis	Medication Details	Are you fully cured? Yes/No
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		

VII. CONCURRENT/PREVIOUS INSURANCE POLICY DETAILS

Are you having existing Health Policy of Future Generali or are you insured under any other Health Insurance Policy?
YES ☐ NO ☐
(If YES, please provide details in below table)

Insured Name	Policy Number	Insurer Name	Policy Period		Sum Insured	Claim Lodged (if yes, give details)	Product Name
			From	To			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			

Are you applying for portability / migration?	☐ Yes ☐ No (If yes, portability / migration form to be completed and attached)

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VIII. PREMIUM PAYMENT AND BANK 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 Details:

Payment Option : Cheque ☐ Demand Draft ☐ Fund Transfer ☐ Pay Order ☐
Debit Card ☐ Credit Card ☐ Cash ☐

Premium Amount : ₹_____ Amount in Words: _____

Account Holder Name : _____

Instrument Number : _____ Instrument Date : _____

Instrument Amount : _____ Bank Name : _____

GSTIN : _____ (If more than one GSTIN, kindly attach an annexure with details)

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/-.

IX. ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER

(Email Id is mandatory)

Do you have an EIA : ☐ Yes ☐ No If no, do you wish to apply for EIA : ☐ Yes ☐ No

If yes, please quote the EIA number : <<_____>>

If applied, please mention your preferred Insurance Repository : <<_____>>

Email Id (Registered with Insurance Repository) : <<_____>>

Your Policy will be credited in your EIA account and your address details as mentioned in the EIA shall override the address provided in this proposal for Insurance. We request you to inform the Repository of any changes in the details immediately.

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X. 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 ☐

XI. 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 that:
   - There is no other material / relevant information, that has not been disclosed to FGIICL 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 FGIICL.
   - I agree to receive Service-related information from FGIICL and its service providers, through electronic and telecom modes including WhatsApp and further understand that no unsolicited information will be sent to me.
   - The information/ data provided by me through this Proposal Form, to FGIICL and / or FGIICL authorized personnel / agency shall be stored by FGIICL, throughout the currency of my relationship with FGIICL and used for the purpose relating to my proposal for insurance cover and or servicing policies issued in my favour, whether by FGIICL or its authorized partners. I also understand that the said storage is necessary for my consumption of the services and consent to not hold FGIICL and / or its authorized partners / agency / personnel liable for legal 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/our 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 FGIICL reserves the right to call for documents and information to establish the source of funds and has 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

8) I/We hereby confirm that the premium payment has been paid by _____, who is having an insurable interest in my/our policy under this application form. In case of any refund, please process the same in below mentioned proposer's bank account.

9) I am (please tick all that are applicable) ☐ HNI ☐ NRI ☐ Politically Exposed Person ☐ Jeweller ☐ NGO ☐ Film Actor ☐ Producer ☐ Others

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 FGIICL Privacy Policy, available at https://general.futuregenerali.in/privacy-policy.

11) **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 Future Generali India 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.

12) I consent to the fact that FGII 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 above-mentioned 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 FGII hereafter. In case of any modification, the applicable information will be provided to FGII for updating the CKYC Registry Records.

Optional Declaration:

I 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 empanelled third-party vendor ☐ 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://general.futuregenerali.in/)*

Date: Place: Proposer Name: Signature / Thumb Impression of Proposer:

XII. A INTERMEDIARY DECLARATION

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. I have further informed the proposer that the details provided herein shall form the basis of the contract of insurance between FGIICL and the proposer. I have also 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 FGIICL, be treated as null and void and the premium amount against the policy may be forfeited to FGIICL.

XII. B VERNACULAR DECLARATION

 # applicable only when proposer has signed in thumb impression and is witnessed by someone other than agent/ employee of FGIICL

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.
I hereby declare that I have clearly explained the content of this form to the proposer and the proposer has affixed the thumb impression above after fully understanding the content thereof.

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Name of Witness : Signature of Witness :

Date : Place : Signature of Agent / Intermediary :

XII. C 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 FGIICL may issue;
d) Coordinate with designated service providers engaged with/by FGIICL 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 FGIICL may issue;
d) Coordinate with designated service providers engaged with/by FGIICL 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 :

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Name of Witness	:	Signature of Witness	:
Date	:	Place	:

Prohibition of Rebates: Section 41 of the Insurance Act, 1938 (and amendments thereof)

1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of 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 prospectus or tables of the insurers.
2) Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to ten lakh rupees.

FOR OFFICE USE ONLY

Intermediary Name	:	Intermediary Code	:
Sales Manager Name	:	Sales Manager Code	:

ISO No. FGH/UW/RET/303/03

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ANNEXURE – Only applicable if number of persons to be insured is more than 6.

III. PROPOSED INSURED DETAILS*				
	Insured 7	Insured 8	Insured 9	Insured 10
Name				
Gender				
Date of Birth (DD/MM/YYYY)				
Marrital Status				
ABHA No^^				
Relationship with Proposer				
Height (Cm)				
Weight (Kg)				
Occupation				
Sum Insured (Base Cover)				
Optional Cover				
Critical Illness (For members aged between 18 to 65 years only)				
Personal Accident Cover (For members aged between 3 to 65 years only)				
Voluntary Co-payment?	☐ 10% ☐ 20% ☐ 30%			
Please attach age proof document for each insured. The below age proofs will be considered:				
Passport, PAN Card, Driving License, School/ College leaving certificate, Letter from recognized public authority.				

V MEDICAL AND HEALTH INFORMATION*					
Please answer below mentioned questions		Insured 7	Insured 8	Insured 9	Insured 10
1.	Do you consume tobacco in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Type – Cigarette/Beedi/Cigar/Gutkha/Others				
	If you have stopped smoking – Since when	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY
2.	Do you consume alcohol in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Type – Beer/Hard liquor/Wine/Others				

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3.	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity? Yes ☐ No ☐				
	Has any person to be insured is currently suffering from/suffered in the past/taking treatment for any illness/disease or injury for following medical conditions? YES ☐ NO ☐ (If yes, please select the disease for the specific insured person)				
	a) Psychiatric/Mental/Sleep Disorder	☐	☐	☐	☐
	b) Stroke/Epilepsy/Paralysis or other brain / nervous system disorders	☐	☐	☐	☐
	c) Disease related to Ear/Nose/Throat	☐	☐	☐	☐
	d) Tuberculosis/Asthma or any lung / respiratory disorder	☐	☐	☐	☐
	e) Hypertension/Chest pain/heart disease	☐	☐	☐	☐
	f) Liver Disease/Ulcers (stomach/duodenum)/ Gall stones/Hepatitis/other digestive Disorders	☐	☐	☐	☐
	g) Kidney Failure/Dialysis/Kidney Stones/ Prostate/ other kidney disorders	☐	☐	☐	☐
	h) HIV/AIDS/ Sexually Transmitted Disease	☐	☐	☐	☐
	i) Diabetes/ Thyroid or any other endocrine disorders	☐	☐	☐	☐
	j) Arthritis, Spondylitis, Joint Pain, Slip Disc, Spinal Disorder or any other disorder of muscle/ bone/ joint	☐	☐	☐	☐
	k) Cancer/Tumour- Benign or Malignant	☐	☐	☐	☐
	l) Anaemia or any other blood disorder	☐	☐	☐	☐
	m) Females Specific – Fibroid / Cyst/ Fibroadenoma/ Breast disorder or any other Gynaecological Disorder	☐	☐	☐	☐
	n) Any accidental injury that has caused disability / hospitalization	☐	☐	☐	☐
	o) Treatment for Infertility or has been advised for?	☐	☐	☐	☐
	p) Others (Please Specify with diagnosis)	☐	☐	☐	☐
4.	Is any of the female insured pregnant? If yes, please mention the expected date of delivery	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY

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VI. ADDITIONAL INFORMATION (In case the number of persons to be insured is more than 6, please fill the attached Annexure)				
If any of the proposed insured person is suffering from/suffered in the past/taking treatment for any illness/disease or injury and the same is declared in above Section -V.3, then please provide further details				
Insured Name	Name of Illness/ Surgery	Date of first diagnosis	Medication Details	Are you fully cured? Yes/No
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		