

**SURROGACY HEALTH COVER  
PROPOSAL FORM**

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

**IMPORTANT GUIDELINES FOR COMPLETION OF THE FORM**

This Policy is specially designed to cover an insured person who is,

(A) A Surrogate Mother- To avail the benefits offered under this product, the product shall only be bought before the implantation of the human embryo in the Surrogate mother's womb.

**OR**

(B) An Oocyte Donor- To avail the benefits offered under this product, the product shall only be bought before initiation of the Oocyte retrieval procedure.

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 also might lead to cancelation of policy. 3
3. It is important to fill all questions, information for fields marked with asterisk [\*] is mandatory.
4. Cover shall commence not earlier than the date and the time of acceptance and subsequent to payment of the premium.

Receive Date	Branch Code	Branch Name
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**Intermediary Details**

Intermediary Name:	
Intermediary Code:	
Intermediary Contact Details:	

**I. PROPOSER DETAILS**

Proposer Name\* :  Mr.  Mrs.  Ms. \_\_\_\_\_  
 Gender \* :  Male  Female  Others \_\_\_\_\_

Date of Birth\* :       Age (in years) : \_\_\_\_\_  
 \* : \_\_\_\_\_

Profession :  Salaried  Self- Employed  Others : <<Specify details >>  
 Occupation and Nature of Business / Work : \_\_\_\_\_

PAN /Form60/61 : \_\_\_\_\_ (Mandatory where the premium exceeds Rs. 50,000/- in cash and where premium exceeds Rs. One Lakh in any mode)

Address Landmark : \_\_\_\_\_ City / Town : \_\_\_\_\_

State	:	_____	Pin	:	_____
Contact Details	Phone No.*	:	_____	Code	:
				Email	:
				ID*	:
Are you an existing Future Generali Customer?	:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If Yes, Existing Policy No.	:	_____	Customer ID No.	:	_____

<b>II. POLICY/PLAN DETAILS*</b>					
Policy Type	:	Individual Basis			
Insured Person	:	<input type="checkbox"/> Surrogate Mother	<input type="checkbox"/> Oocyte Donor		
Sum Insured Applicable	:	<input type="checkbox"/> 2,00,000	<input type="checkbox"/> 1,00,000		
		<input type="checkbox"/> 3,00,000	<input type="checkbox"/> 3,00,000		
		<input type="checkbox"/> 5,00,000			
Policy Term	:	3 years	1 Year		
Proposed Policy Period	:	From	:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	To
				<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	

Please provide supporting documents for Surrogate Mother/Oocyte Donor.

<b>III. PROPOSED INSURED DETAILS*</b>		
Sr. No.	Name	Insured 1
1	Name of the Insured	
2	Gender	Female
3	Date of Birth (DD/MM/YYYY)	
4	Age	
5	Relationship with Proposer	<<Surrogate Mother>><< Oocyte Donor>>
6	ABHA Number^^	
7	Nationality	Indian
8	Height (cms)	
9	Weight (Kgs)	
10	Occupation	
11	Marital Status	

^^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>

<b>IV. NOMINEE DETAILS*</b>			
In the event of the death of the Policyholder (Proposer), any payment due under the Policy shall become payable to the Nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. The Nominee for persons proposed to be insured shall be the Proposer himself/herself.			
Nominee Name	Date of Birth	Age	Relationship with Proposer
If Nominee is minor, please give the name and address of the appointee and relationship with the minor			
Appointee Name	Date of Birth	Age	Relationship with Minor (Proposer)

<b>V. MEDICAL AND HEALTH INFORMATION*</b>	
Please answer below mentioned questions	Insured 1

1.	Do you consume tobacco in any form?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Type- Cigarette/Beedi/Cigar/ Gutkha/Others		
	If you have stopped smoking – Since when	MM/YYYY	
2.	Do you consume alcohol in any form?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		
	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 <input type="checkbox"/> NO <input type="checkbox"/> (If yes, please select the disease for the specific insured person)		
	a) Psychiatric/Mental/Sleep Disorder	<input type="checkbox"/>	
	b) Stroke/Epilepsy/Paralysis or other brain / nervous system disorders	<input type="checkbox"/>	
	c) Disease related to Ear/Nose/Throat	<input type="checkbox"/>	
	d) Tuberculosis/Asthma or any lung / respiratory disorder	<input type="checkbox"/>	
	e) Hypertension/Chest pain/heart disease	<input type="checkbox"/>	
	f) Liver Disease/Ulcers (stomach/duodenum)/ Gall stones/Hepatitis/other digestive Disorders)	<input type="checkbox"/>	
	g) Kidney Failure/Dialysis/Kidney Stones/ Prostate/ other kidney disorders	<input type="checkbox"/>	
	h) HIV/AIDS/ Sexually Transmitted Disease	<input type="checkbox"/>	
	i) Diabetes/ Thyroid or any other endocrine disorders	<input type="checkbox"/>	
	j) Arthritis, Spondylitis, Joint Pain, Slip Disc, Spinal Disorder or any other disorder of muscle/ bone/ joint	<input type="checkbox"/>	
	k) Cancer/Tumour- Benign or Malignant	<input type="checkbox"/>	
	l) Anaemia or any other blood disorder	<input type="checkbox"/>	
	m) Females Specific – Fibroid / Cyst/ Fibroadenoma/ Breast disorder or any other Gynaecological Disorder	<input type="checkbox"/>	
n) Any accidental injury that has caused disability /hospitalization	<input type="checkbox"/>		
o) Treatment for Infertility or has been advised for?	<input type="checkbox"/>		
p) Others (Please Specify with diagnosis)	<input type="checkbox"/>		

**VII. PREMIUM PAYMENT AND BANK DETAILS\***

Payment Frequency : Single

Aadhar E-mandate \* :  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	: <input type="checkbox"/> Cheque	: <input type="checkbox"/> Demand Draft	: <input type="checkbox"/> Fund Transfer	: <input type="checkbox"/> Pay Order	: <input type="checkbox"/> Debit Card
	: <input type="checkbox"/> Cash	: <input type="checkbox"/> Credit Card			
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)				
<p>Please fill up the request for authorization 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/-.</p>					

<b>VIII. ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER</b>					
(Email Id is mandatory)					
Do you have an EIA	: <input type="checkbox"/> Yes	<input type="checkbox"/> No	If No, do you wish to apply for EIA	: <input type="checkbox"/> Yes	<input type="checkbox"/> 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.					

<p><b>IX. 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.</b></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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<b>X. DECLARATION</b>	
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 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 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 have 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  Jeweler  NGO  Film Actor  Producer  Others
- 10) **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

**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 empaneled 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.futuregeneral.in/>)

Signature / Thumb  
Impression of Proposer:

Date: DD/MM/YY Place: Proposer Name: \_\_\_\_\_

**XI. 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.

<b>XI. B VERNACULAR DECLARATION</b>		
# 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.		
Name of Witness :	_____	Signature of Witness :
Date :	Place :	Signature of Agent / Intermediary :
POSP Name :	POSP Code :	POSP PAN No. :
_____	_____	_____

<b>Prohibition of Rebates: Section 41 of the Insurance Act, 1938 (and amendments thereof)</b>	
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.	

<b>FOR OFFICE USE ONLY</b>			
Intermediary Name :	_____	Intermediary Code :	_____
Sales Manager Name :	_____	Sales Manager Code :	_____



ISO No. FGH/UW/RET/291/01

Future Generali India Insurance Company Limited. IRDAI Regn. No. 132 | CIN: U66030MH2006PLC165287.

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