

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

PROPOSAL FORM

FUTURE HEALTH SURPLUS

IMPORTANT GUIDELINES:

- 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.
- It is important to fill all questions, information for fields marked with asterisk [*] is mandatory
- 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:** _____

DESIRED PERIOD OF INSURANCE*:

D	D	M	M	Y	Y	Y	Y
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D	D	M	M	Y	Y	Y	Y
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SECTION I. PROPOSER DETAILS*:

Name of the Proposer*		
	Sur Name	First Name	Middle Name
Full Address*			
State			Pin code
Contact Number	Landline:	Mobile*:	
Email Id			
Date of Birth*	DD/MM/YYYY		Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Third Gender
PAN	Aadhaar Number		
Note: PAN number is mandatory where the premium is Rs.50000/- and above in cash and additionally PAN copy is mandatory where premium is more than One Lakh in any mode.			
e-IA Number <small>(e-Insurance Account Number)</small>	If not available request you to kindly download the form from our website and request you to kindly submit along with this proposal form		
Marital Status*	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Divorced		
Nationality*			
Occupation*	<input type="checkbox"/> Service <input type="checkbox"/> Self Employed <input type="checkbox"/> Others:		
Are you an existing Future Generali customer*? If yes, please provide: Existing Policy No.:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Customer ID No.:			

SECTION II. PRODUCT DETAILS*:

Note: For Family Floater plan: - Family means- Self, Spouse and your 2 dependent children up to the age of 25 years

Type: Individual Family Floater

Plan Details:

Plan	A	B	C	D	E
Sum Insured (in Rs)	3 lakhs	5 lakhs	5 lakhs	7 lakhs	10 lakhs
Deductible (in Rs)	2 lakhs	2 lakhs	3 lakhs	3 lakhs	5 lakhs

SECTION III. DETAILS OF THE INSURED*

Details	PRIMARY INSURED	SPOUSE	CHILD 1	CHILD 2
Name				
Gender				
Date of Birth/ Age				
Height & Weight				
Marital Status				
Nationality				
Educational Qualification				
Occupation				
Organization				
Income				
Nominee Name*				
Relationship with Proposer				
Plan option required in case of individual				
In case of floater (a single plan to be selected)				
Premium				

*In case the nominee is a minor, please provide the name of the guardian also. If parents are covered concurrently child above the age of 90 days can be covered under this policy

SECTION IV. HEALTH DETAILS* (Please answer by writing "Yes" or "No" against each of the questions. A mere dash is not sufficient.)

Sr. No.	Question	Primary Insured		Insured 2		Insured 3		Insured 4	
1	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity?	Y/N		Y/N		Y/N		Y/N	
2	Do you regularly consume /smoke Tobacco, Alcohol ?(If yes, specify the details separately in the format below)	Y/N		Y/N		Y/N		Y/N	
	Substance	Qty/ day	No of years since consuming	Qty/ day	No of years since consuming	Qty/ day	No of years since consuming	Qty/ day	No of years since consuming
	Tobacco								
	Alcohol								
3	Have you ever suffered or are suffering from any of the following:								

a	Diabetes Mellitus	Y/N	Y/N	Y/N	Y/N
b	High Blood Pressure, Heart disease including Ischaemic Heart Disease (IHD)/ Rheumatic Heart Disease	Y/N	Y/N	Y/N	Y/N
c	Chest pain, stroke, asthma, any respiratory condition, cancer or tumor or lump of any kind, 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	Y/N	Y/N	Y/N	Y/N
4	Have you ever received any treatment/ medication due to any medical condition?	Y/N	Y/N	Y/N	Y/N
5	Any other diseases or ailments not mentioned above?	Y/N	Y/N	Y/N	Y/N

If answer to any of above is "Yes", please provide details: (For additional information please attach separate sheets)

Details	Primary Insured	Insured 2	Insured 3	Insured 4
Details of the Treating/ Family Doctor	Name: Address:	Name: Address:	Name: Address:	Name: Address:
Name of disease/ illness/ injury suffering from				
Treatment/ medication/ received/ receiving				
When first treated				
Is fully cured?				

SECTION V. OTHER HEALTH INSURANCE INFORMATION* (Details of cover from Future Generali India Insurance Company Ltd or any other Health Insurance)

Details	Primary Insured	Insured 2	Insured 3	Insured 4
Insured member				
Policy or Proposal No				
Company Name				
Basic Sum Insured				
Period of Insurance	From: dd/mm/yy To: dd/mm/yy	From: dd/mm/yy To: dd/mm/yy	From: dd/mm/yy To: dd/mm/yy	From: dd/mm/yy To: dd/mm/yy
Cumulative Bonus amount				
Cumulative Bonus				
% Claims received for				
Claims received/ receivable (Rs.)				

Note: -1) In case of Portability/ Migration, kindly fill Portability/ Migration Request Form along with this form.

SECTION VI. DECLARATION & AUTHORIZATION*

- 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.
- 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.
- 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.
- 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.
- 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.
- I hereby authorize the company to authenticate and/or verify my Aadhaar number for e-KYC purpose
 I/ We hereby declare that the premium for the said policy is paid out of the legally declared and assessed sources of my/ our income OR
 I/ We hereby declare that the premium is paid from the Bank Account of Mr. / Ms. _____, the payment is allowed under the Income Tax Act 1961, and there is insurable interest with the payee.

Optional Declaration

- I/We also authorise the insurer to pay claim in case of the insured person's death or if he/she is incapacitated, to the nominee mentioned in the proposal form.
- I agree that this proposal and the declaration shall be the basis of the contract between me and FUTURE GENERALI INDIA INSURANCE CO LTD and I/We agree to accept a policy, subject to the conditions prescribed by FUTURE GENERALI INDIA INSURANCE CO LTD.
- 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://general.futuregenerali.in/>)

Date: DD / MM / YYYY Place:

Proposer's Name:

Proposer's Signature/ Thumb Impression:

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 different language/or is not literate)

Intermediary / Agent Name:

Intermediary / Agent Signature:

*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 thereafter the proposer has fixed the thumb impression above after fully understanding the content thereof.

Intermediary / Agent Name:
Witness Name:
Date:

Intermediary / Agent Signature:
Witness Signature:
Place

SECTION VII. PAYMENT DETAILS*

Premium paid by Cash/ Cheque No		Date:	DD	MM	YYYY
Bank Name		Amount (INR):			
Amount (in words)					
GSTIN (If more than one GSTIN, kindly attach an annexure with details)					
<i>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 if the Premium is more than ₹25000/-</i>					

SECTION VIII. FOR OFFICE USE ONLY

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

SECTION 41 SUB-SECTION (2) OF INSURANCE LAWS (Amendment) ACT, 2015 - PENALTY FOR ACCEPTING AND/OR OFFERING OF REBATE:

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.



ISO No. FGH/UW/RET/07/14

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

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