FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

PROPOSAL FORM
CORONA KAVACH POLICY,
FUTURE GENERALI INDIA INSURANCE COMPANY LIMITED

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

PERIOD OF INSURANCE DESIRED*: D D M M Y Y Y Y — D D M M Y Y Y Y

1. 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*	☐ Male ☐ Female ☐ Third Gender
PAN			
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 (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*		
Marital Status*	☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced		
Nationality*			
Occupation*	☐ Service ☐ Self Employed ☐ Health care worker##: _____ ☐ Others: _____		
Are you an existing Future Generali customer*? If yes, please provide: Existing Policy No.: _____ Customer ID No.: _____	☐ Yes ☐ No		

##***Health care worker*** *for the purpose of this policy shall mean doctors, nurses, midwives, dental practitioners and other health professionals including laboratory assistants, pharmacists, physiotherapists, technicians and people working in hospitals. Insured need to provide an ID proof along with the proposal form, in case he/she is a health care worker.*

2. FAMILY DOCTOR DETAILS*

Name of the Dr*	……. Sur Name	……. First Name	……. Middle Name
Full Address*			
State		Pin code	
Contact Number	Landline:	Mobile:	
Email Id			

3. DETAILS OF INSURED*

Note: Proposer can propose cover only for Self, Spouse, Dependent Children, Parents and Parents-in-laws.

DEFINITION:-Family means – Self, Spouse, Dependent Children (unmarried and up to the age of 25 years), Parents and Parent-in-laws.

Note: -#For Individual plan kindly indicate the details of all the members to be covered in the table below.

#For Family Floater plan, the Plan option and Sum Insured will float over the family members covered under the policy. Please do not fill anything in Premium Computation Column.

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6	Insured 7	Insured 8	Insured 9	Insured 10
Name										
Gender										
Date of Birth/ Age										
Relationship with Proposer										
Height										
Weight										
Health care worker##	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Occupation										
Nominee Name										
Relationship of Nominee with Insured										
Sum Insured opted (Individual Plan) ₹ 50000 to Max. ₹ 5 Lacs (in multiples of ₹ 50000)										
Hospital Daily Cash	☐Opted ☐Not Opted	☐Opted ☐Not Opted	☐Opted ☐Not Opted	☐Opted ☐Not Opted	☐Opted ☐Not Opted	☐Opted ☐Not Opted	☐Opted ☐Not Opted	☐Opted ☐Not Opted	☐Opted ☐Not Opted	☐Opted ☐Not Opted
Sum Insured opted (Family Floater Plan) *₹ 50000 to Max. ₹ 5 Lacs (in multiples of ₹ 50000)*										
Hospital Daily Cash	☐Opted ☐Not Opted									
Premium computation (including GST)[#]										

([#] Premium would be applicable as per the completed age of each insured member. A standard individual premium would be applicable for each insured member. The floater discount will be applicable as per the number of members covered under the policy.)

*([##]**Health care worker** for the purpose of this policy shall mean doctors, nurses, midwives, dental practitioners and other health professionals including laboratory assistants, pharmacists, physiotherapists, technicians and people working in hospitals. Insured need to provide an ID proof along with the proposal form, in case he/she is a health care worker)*

4. Policy term* (please tick the term opted): ☐ 3 ½ months (105 days) ☐ 6 ½ months (195 days) ☐ 9 ½ months (285 days)

5. Health Questions* (Please answer "Y" for Yes or "N" for No against each of the questions.)

Details	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity?	Are / were you a regular smoker ? (Yes/ No)	Does any person to be insured suffer or has suffered from any of the following?					Are you/ fully cured /recovered? (Yes/ No). Please provide further details.	Have you in the last 30 days or are you presently suffering from Fever, cold, respiratory complaints	Whether You or any family member / or any person living with you has/have suffered from COVID infection in past 30 days?
			Hypertension	Diabetes	Asthma	Any other respiratory conditions	Any other conditions			
Insured 1	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
Insured 2	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
Insured 3	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
Insured 4	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
Insured 5	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
Insured 6	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
Insured 7	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
Insured 8	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
Insured 9	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No

Insured 10	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No

Please confirm if any of the persons to be insured is pregnant (For females only) _____

6. DETAILS OF OTHER CONCURRENT HEALTH INSURANCE POLICIES*:

Insured Person	Do you have any other Health Insurance policy with Future Generali India Insurance or any other insurance company?	Policy No	Name of the insurer	Policy sum insured	Period of Insurance	Claims Received/ Receivable (in ₹)
Insured 1	☐ Yes ☐ No					
Insured 2	☐ Yes ☐ No					
Insured 3	☐ Yes ☐ No					
Insured 4	☐ Yes ☐ No					
Insured 5	☐ Yes ☐ No					
Insured 6	☐ Yes ☐ No					
Insured 7	☐ Yes ☐ No					
Insured 8	☐ Yes ☐ No					
Insured 9	☐ Yes ☐ No					
Insured 10	☐ Yes ☐ No					

7. 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 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.

☐ 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

1. 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
2. I hereby authorize the company to authenticate and/or verify my Aadhaar number for e-KYC purpose

*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

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

_____ Prospect's Thumb Impression

Vernacular Declaration

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent/ employee of the company)

Name of the Proposer:

The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same:

Name of Person who has explained the particulars: _____
Signature of Person who has explained the particulars: _____
Proposer's Signature/ Thumb Impression: _____ **Date:** _____**Place:**_____
Witness Signature: _____ **Witness Name:** _____

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)					
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/-					

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/245/02
Future Generali India Insurance Company Limited. IRDAI Regn. No. 132 | CIN: U66030MH2006PLC165287. Regd. and Corp. Office: 801 and 802, 8th floor, Tower C, Embassy 247 Park, L.B.S. Marg, Vikhroli (W), Mumbai - 400083. Call us at: 1800-220-233 / 1860-500-3333 / 022-67837800 | Fax No: 022 4097 6900 | Website: https://general.futuregenerali.in | Email: fgcare@futuregenerali.in. Trade Logo displayed above belongs to M/S Assicurazioni Generali - Societa Per Azioni and used by Future Generali India Insurance Co Ltd. under license.