FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

PROPOSAL FORM
SURAKSHIT LOAN BIMA

***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.

Received date: ___ ___ / ___ ___ / ___ ___ ___ ___ Branch code: _____ Branch name: _____

	APPLICANT	CO-APPLICANT
Name	…….. …….. ……..... Sur Name First Name Middle Name	…….. …….. ……..... Sur Name First Name Middle Name
Relationship		Relationship with Applicant: ……
Nationality		
Father's /Husband Name		
Current Address		
Current Address is	☐ Self-Owned ☐ Rented ☐ Co. Leased	☐ Self-Owned ☐ Rented ☐ Co. Leased
Contact Number	……(Landline) ……(M)*	……(Landline) ……(M)*
Email Id		
Date of Birth/ Gender	…… Age : ……Yrs M / F	…… Age : ……Yrs M / F
Marital Status	☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced	☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced
No. Of Dependents	……Children ……Others	……Children ……Others
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 (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*	
Occupation	☐ Employed ☐ Self Employed (Full time / Part time)	☐ Employed ☐ Self Employed (Full time / Part time)
Education Qualification		
Employer/ Business Name		
Type of Industry		
Designation & Nature of Job		
Monthly Income		
Other Income (If Any)	₹…… Source……	₹…… Source……
Employer / Business Address		
Employer / Business Contact Number		
Years in Present Occupation		
Loan Account Number		
Loan Amount		
Loan Tenure		
Policy Tenure	☐ 1 Year ☐ 2 Years ☐ 3 Years	
Period of insurance desired	**From:** DD / MM / YYYY **To:** DD / MM / YYYY	
Plan Opted	☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E	
Type of Loan	☐ Home Loan ☐ Personal Loan ☐ Auto Loan ☐ Others (Pls specify): _____	
Sum Insured		
Loss of Job Opted	☐ Yes ☐ No	
Purpose of Loan		
Type of Property		
Property Ownership		
Date of Loan Disbursement	DD / MM / YYYY	
Location of Property		
Financier / Bank		

**(In case where there are more than 2 applicants, Annexure I attached needs to be filled in for each applicant, along with this proposal form)*

MEDICAL INFORMATION

1. **HEALTH QUESTIONS :***(Please answer by ticking either "yes" or "no" against each of the questions)*

Sr. No	DETAILS	APPLICANT	CO-APPLICANT
1	Has your Health Insurance / Life Insurance proposal ever been declined?	☐ Yes ☐ No	☐ Yes ☐ No
2	Are you now in good health & entirely free from any mental / physical impairments or deformities (including congenital deformities)?	☐ Yes ☐ No	☐ Yes ☐ No
3	Height / Weight	In CMs: _____ In KGs: _____	In CMs: _____ In KGs: _____
4	Have you lost more than 5 kgs weight in last 3 months?	☐ Yes ☐ No	☐ Yes ☐ No
5	Have you ever suffered from or do you suffer from Diseases of the circulatory system E.g. Heart Disease, Chest pain, High blood pressure, Diseases of Arteries / Veins?	☐ Yes ☐ No	☐ Yes ☐ No

6	Have you ever suffered from or do you suffer from Diabetes Mellitus, Cancer or Tumor of any kind, or any diseases of Blood Glands, Spleen, Ears Eyes, or Skin?	☐ Yes ☐ No	☐ Yes ☐ No
7	Have you ever suffered from or do you suffer from diseases of the Respiratory system (Lung Diseases) e g, Tuberculosis, Asthma. Emphysema, Pneumonia?	☐ Yes ☐ No	☐ Yes ☐ No
8	Do you have / had any complaints of difficulty in Breathing, Blood in Sputum or Persistent Respiratory Infections?	☐ Yes ☐ No	☐ Yes ☐ No
9	Have you ever suffered from or do you suffer from any disease of Genitourinary System / Kidneys?	☐ Yes ☐ No	☐ Yes ☐ No
10	Do you have / had any complaints of swelling over face / Lower limbs?	☐ Yes ☐ No	☐ Yes ☐ No
11	Have you ever suffered from or do you suffer from Diseases of the Nervous system or Mental Disorders e.g. Stroke, Epilepsy, Fits / Fainting attacks, Frequent Headache, Psychiatric Disorders (for e.g. Depression etc.)?	☐ Yes ☐ No	☐ Yes ☐ No
12	Do you have / had any complaints of Weakness in Limbs, tingling numbness, loss of Power in limbs or any other similar complaints?	☐ Yes ☐ No	☐ Yes ☐ No
13	Have you at any time suffered from recurrent episodes of Hepatitis, / Blood in Vomiting or Stool, recurrent Diarrhea?	☐ Yes ☐ No	☐ Yes ☐ No
14	Have you ever had, or been told that you had, or been treated for, or are you intending to seek treatment for HIV, AIDS or AID-related conditions?	☐ Yes ☐ No	☐ Yes ☐ No
15	Have you or any of your immediate family members (Father / Mother / Brother or Sister) have /had Cancer, Heart Attack, and Stroke? Was it prior to 60 yrs of age?	☐ Yes ☐ No	☐ Yes ☐ No
16	Have you ever taken Narcotics / other habit forming Drugs or being treated For the same?	☐ Yes ☐ No	☐ Yes ☐ No
17	Have you been treated for Alcoholism related Diseases?	☐ Yes ☐ No	☐ Yes ☐ No
18	Do you smoke? Or Chew Tobacco If yes, how many cigarettes / beedi's or grams of tobacco per day? _____	☐ Yes ☐ No	☐ Yes ☐ No
19	Do you consume alcohol? If yes, What type (Spirit, wine, beer etc?) And quantity per week? _____	☐ Yes ☐ No	☐ Yes ☐ No
20	Have you suffered from any other Diseases or Ailments not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No
21	Have you taken treatment / done investigations, for e. g (CT scan, X rays etc) for any ailment?	☐ Yes ☐ No	☐ Yes ☐ No
	If the answer is "Yes" for any of the above please provide details in the space given below.		

2. Have you or the co applicant suffered / are suffering from any disease / illness/ injury? ☐ Yes ☐ No
If yes, indicate in the table below.

Sr. No	Name	Name of Disease/ ailment/ injury Suffering from	First Date of Diagnosis	When First treated	Name of attending medical practitioner with address and telephone no.	Details of current symptoms (onset, intensity and duration)	If fully cured? Answer Yes / No	Is there any further Consultation planned

3. Do you or co-applicant have other current or pending critical illness Insurance and/or personal accident with Future Generali India Insurance Co. Ltd or from any other Insurance Company? If yes, please give the details as mentioned below:

	Applicant	**Co-Applicant**
Sum Insured		
Type of Policy		
Insured since		
Period of Insurance	DD / MM / YYYY **To** DD / MM / YYYY	DD / MM / YYYY **To** DD / MM / YYYY
Any Exclusions or Special Conditions applied in the policy		
Claims made, if any		

Family Doctor Details

Name: Dr. ……..
Contact Nos. : ……..
Clinic/ Hospital/ Nursing Home No. : ……

Nominee*

1. Applicant :

Nominee*	Name of Nominee	Relationship with Applicant	DOB	Age	% of Sum Insured
Nominee 1					
Nominee 2					

2. Co- Applicant

Nominee*	Name of Nominee	Relationship with Co-Applicant	DOB	Age	% of Sum Insured
Nominee 1					
Nominee 2					

** Nominee for self has to be one of the below mentioned relations.*
"Father, Mother, Son, Daughter, Spouse & Others "
If Nominee is "Others" please specify:

IMPORTANT NOTE:

- The Company will not be on risk until the proposal and insured person's details have been accepted by the company and communication of the acceptance has been given to the proposer in writing on full payment of premium
- This proposal for insurance will be the basis of any subsequent insurance policy that we issue to you. It is essential that you answer fully and accurately all of the questions contained in this proposal, and that you provide us with any and all additional information relevant to the risk to be insured or our decision as to the acceptance of the risk or the terms upon which it should be accepted. Your failure to comply with this obligation now may result in the rejection of your claim and the avoidance of your policy when a claim is made. If you are in any doubt about the information to be given, please seek the advice and guidance of your insurance advisor or agent. If there is insufficient space in this proposal for you to provide relevant information, whether as requested or otherwise, please attach a separate sheet to this proposal and return it to us.
- The Company reserves the right to reject the said proposal or to terminate the insurance contract unilaterally and/ or freeze the funds if the Customer or persons associated with him/her, found to be named in any recognized black list.

HEALTH & DATA DECLARATION

a) 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.
b) 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.
c) 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.
d) 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.
e) 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.
f) I hereby authorize the company to authenticate and/or verify my Aadhaar number for e-KYC purpose
g) 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 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 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.

*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/)*

Applicant's Name: _____ Applicant's Signature/ Thumb Impression: _____

Co-Applicant's Name/ Thumb Impression: _____ Co-Applicant'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: **Intermediary / Agent Signature:**
Witness Name: **Witness Signature:**
Date: **Place**

PAYMENT DETAILS:

Premium paid by Cash / Cheque:	Date:
Bank:	Amount (₹):

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 ₹25,000/-

FOR OFFICE USE ONLY

Intermediary's Name: Intermediary's Code:
Sales Manager's Name: Sales Manager's Code:

SECTION 41 OF INSURANCE ACT, 1938-PROHIBITION OF REBATES:

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 of risk relating to lives or property in India, any rebate of whole or part of the commission payable or any rebate of the 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 published prospectuses or tables of the Insurer. Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to Ten Lakh Rupees.

ANNEXURE I

LIST OF CO-APPLICANTS PROPOSED FOR INSURANCE
Note: 1. This Annexure will be attached to and forming part of the proposal form and policy to be issued.

Details of Insured:

	CO-APPLICANT 2	CO-APPLICANT 3
Name	…….. …….. …….. Sur Name First Name Middle Name	…….. …….. …….. Sur Name First Name Middle Name
Relationship	Relationship with Applicant: ……	Relationship with Applicant: ……
Nationality		
Father's /Husband Name		
Current Address		
Current Address is	☐ Self-Owned ☐ Rented ☐ Co. Leased	☐ Self-Owned ☐ Rented ☐ Co. Leased
Contact Number	……..(Landline) ……..(M)*	……..(Landline) ……..(M)*
Email Id		
Date of Birth/ Gender	…….. Age : ……Yrs M / F	…….. Age : ……Yrs M / F
Marital Status	☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced	☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced
No. Of Dependents	……..Children ……..Others	……..Children ……..Others
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.*		
Occupation	☐ Employed ☐ Self Employed (Full time / Part time)	☐ Employed ☐ Self Employed (Full time / Part time)
Education Qualification		
Employer/ Business Name		
Type of Industry		
Designation & Nature of Job		
Monthly Income		
Other Income (If Any)	₹……..…….. Source……	₹……..…….. Source……
Employer / Business Address		
Employer / Business Contact Number		
Years in Present Occupation		
Loan Amount		
Sum Insured		

MEDICAL INFORMATION

1. **HEALTH QUESTIONS :***(Please answer by ticking either "yes" or "no" against each of the questions)*

Sr. No	DETAILS	CO-APPLICANT 2	CO-APPLICANT 3
1	Has your Health Insurance / Life Insurance proposal ever been declined?	☐ Yes ☐ No	☐ Yes ☐ No
2	Are you now in good health & entirely free from any mental / physical impairments or deformities (including congenital deformities)?	☐ Yes ☐ No	☐ Yes ☐ No
3	Height / Weight	In CMs: _____ In KGs: _____	In CMs: _____ In KGs: _____
4	Have you lost more than 5 kgs weight in last 3 months?	☐ Yes ☐ No	☐ Yes ☐ No
5	Have you ever suffered from or do you suffer from Diseases of the circulatory system E.g. Heart Disease, Chest pain, High blood pressure, Diseases of Arteries / Veins?	☐ Yes ☐ No	☐ Yes ☐ No
6	Have you ever suffered from or do you suffer from Diabetes Mellitus, Cancer or Tumor of any kind, or any diseases of Blood Glands, Spleen, Ears Eyes, or Skin?	☐ Yes ☐ No	☐ Yes ☐ No
7	Have you ever suffered from or do you suffer from diseases of the Respiratory system (Lung Diseases) e g, Tuberculosis, Asthma. Emphysema, Pneumonia?	☐ Yes ☐ No	☐ Yes ☐ No
8	Do you have / had any complaints of difficulty in Breathing, Blood in Sputum or Persistent Respiratory Infections?	☐ Yes ☐ No	☐ Yes ☐ No
9	Have you ever suffered from or do you suffer from any disease of Genitourinary System / Kidneys?	☐ Yes ☐ No	☐ Yes ☐ No
10	Do you have / had any complaints of swelling over face / Lower limbs?	☐ Yes ☐ No	☐ Yes ☐ No
11	Have you ever suffered from or do you suffer from Diseases of the Nervous system or Mental Disorders e.g. Stroke, Epilepsy, Fits / Fainting attacks, Frequent Headache, Psychiatric Disorders (for e.g. Depression etc.)?	☐ Yes ☐ No	☐ Yes ☐ No
12	Do you have / had any complaints of Weakness in Limbs, tingling numbness, loss of Power in limbs or any other similar complaints?	☐ Yes ☐ No	☐ Yes ☐ No
13	Have you at any time suffered from recurrent episodes of Hepatitis, / Blood in Vomiting or Stool, recurrent Diarrhea?	☐ Yes ☐ No	☐ Yes ☐ No
14	Have you ever had, or been told that you had, or been treated for, or are you intending to seek treatment for HIV, AIDS or AID-related conditions?	☐ Yes ☐ No	☐ Yes ☐ No

15	Have you or any of your immediate family members (Father / Mother / Brother or Sister) have /had Cancer, Heart Attack, and Stroke? Was it prior to 60 yrs of age?	☐ Yes ☐ No	☐ Yes ☐ No
16	Have you ever taken Narcotics / other habit forming Drugs or being treated For the same?	☐ Yes ☐ No	☐ Yes ☐ No
17	Have you been treated for Alcoholism related Diseases?	☐ Yes ☐ No	☐ Yes ☐ No
18	Do you smoke? Or Chew Tobacco If yes, how many cigarettes / beedi's or grams of tobacco per day?	☐ Yes ☐ No	☐ Yes ☐ No
19	Do you consume alcohol? If yes, What type (Spirit, wine, beer etc?) And quantity per week? _____	☐ Yes ☐ No	☐ Yes ☐ No
20	Have you suffered from any other Diseases or Ailments not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No
21	Have you taken treatment / done investigations, for e. g (CT scan, X rays etc) for any ailment?	☐ Yes ☐ No	☐ Yes ☐ No
	If the answer is "Yes" for any of the above please provide details in the space given below.		

2. Have any of the co-applicant(s) suffered / are suffering from any disease / illness? ☐ Yes ☐ No
   If yes, indicate in the table below.

Sr. No	Name	Name of Disease/ ailment/ injury Suffering from	First Date of Diagnosis	When First treated	Name of attending medical practitioner with address and telephone no.	Details of current symptoms (onset, intensity and duration)	If fully cured? Answer Yes / No	Is there any further Consultation planned

3. Do any of the co-applicant(s) have other current or pending critical illness Insurance and/or personal accident with Future Generali India Insurance Co. Ltd or from any other Insurance Company?
   If yes, please give the details as mentioned below:

Applicant	**Co-Applicant 2**	**Co-Applicant 3**
Sum Insured		
Type of Policy		
Insured since		
Period of Insurance	DD /MM / YYYY **To** DD / MM / YYYY	DD /MM / YYYY **To** DD / MM / YYYY
Any Exclusions or Special Conditions applied in the policy		
Claims made, if any		

Nominee*

1. Co-Applicant 2:

Nominee*	Name of Nominee	Relationship with Applicant	DOB	Age	% of Sum Insured
Nominee 1					
Nominee 2					

2. Co- Applicant 3:

Nominee*	Name of Nominee	Relationship with Co-Applicant	DOB	Age	% of Sum Insured
Nominee 1					
Nominee 2					

* Nominee for self has to be one of the below mentioned relations.
"Father, Mother, Son, Daughter, Spouse & Others "

If Nominee is "Others" please specify:
