IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

IFFCO-TOKIO CRITICAL ILLNESS BENEFIT POLICY (UIN: IFFHLIP19036V011920)

PROPOSAL FORM (URN: CIB/IFFHLIP19036V011920/PF-01)

PROPOSER DETAILS

Name				
Address				
City		State		Pin Code
Email Address		Mobile No.		
PAN				

Policy documents will be sent to the above email-ID Do you still need the physical Copy? Yes☐No ☐

KYC Details (Please attach self-attested photo copies)

KYC Document Name	☐ AADHAR No.** ☐ Voter ID card ☐ Passport ☐ Driving License ☐ NREGA Job card ☐ National Population Register Card
KYC Document Number	

Policy Tenure (1yr/ 2yr/ 3yr) ☐

Proposed Period of Insurance: From_____ To_____

(Subject to acceptance of proposal by Insurer and payment of premium before commencement of Risk)

Business Type (please fill details in annexure 1)

Fresh ☐ ITGI Renewal ☐ Transfer from Other insurer ☐

COVERAGE DETAILS: For Family, kindly provide the details of Insured Person(s) in the below format

S.no.	**Member 1**	**Member 2**	**Member 3**
Name			
Insured Person's* Name			
Relation with the Primary Insured person			
DOB (DD/MM/YY)			
Gender			
Name of the nominee			
Relationship with the nominee			
ABHA Number			
Mobile No. registered with Aadhar			
Sum Insured *			
Mobile No. registered with Aadhar			
Have You Suffered From Any Disease/ Prolonged			

Ailment/ Disablement/ Suffered In Past (Please Mark As Yes/No, if yes please fill details in annexure 5)			

Have you lodged claims under such Policies during last 4 years. Yes☐ No ☐
If YES. Please fill the details in annexure 2.

Is any of the persons proposed for insurance receiving any treatment/ medication or has in past four years received treatment for any medical condition or disability? **Yes☐ No ☐**

If **YES**. Please fill the details in annexure 3.

Have any of the persons proposed for insurance ever suffered from any of the diseases / illness particularly Cancer of specified severity, Myocardial Infarction (First Heart Attack of specific severity), Open Chest CABG, Open Heart Replacement Or Repair Of Heart Valves, Coma Of Specified Severity, Kidney Failure Requiring Regular Dialysis, Stroke Resulting In Permanent Symptoms, Major Organ /Bone Marrow Transplant, Permanent Paralysis Of Limbs, Motor Neuron disease with permanent symptoms, Multiple Sclerosis With Persisting Symptoms, Benign Brain Tumor, Blindness, Deafness, End Stage Lung Failure, End Stage Liver Disease, Loss of speech, Loss of Limbs, Major Head Trauma, Primary (Idiopathic) Pulmonary Hypertension, Third Degree Burns, Parkinson's disease before the age of 50, Alzheimer's disease before the age of 50, Muscular Dystrophy, Surgery of Aorta) **Yes☐ No ☐**

If **YES**. Please fill the details in annexure 4.

If the proposal is a case of portability, then the additional proposal form relating to portability has also to be filled in (as per IRDA draft format).

Premium Detail:

Mode of payment_____Rs._____(including Tax)

Cheque No._____	Cheque date_____	Bank_____

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 IFFCO-Tokio General Insurance Co. Ltd. (herein after referred as "IFFCO-Tokio") 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 IFFCO-Tokio.

d) I declare that I consent to IFFCO-Tokio seeking medical information from any doctor or hospital who/which at anytime 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 am sharing personal information (including Ayushman Bharat Health Account (ABHA) ID, Demographic Information and medical records/ history) of myself and on behalf of all the persons proposed to be insured under the health policy issued/ to be issued by IFFCO-Tokio voluntarily and under authorization of all the persons insured under the health policy.

I fully understand and agree that:

i. My medical records shall be shared with Insurers, Third Party Administrator and medical service providers through ABHA.

ii. personal information provided herein may be used or shared by IFFCO-Tokio, Health Service Provider and/or the Third Party Administrator for the purpose of:

- identification/ authentication, underwriting/ data analysis/ taking measure to respond the medical emergency/ policy and claim servicing.
- storage by IFFCO-Tokio and its lawful agent/ third party for the period as stipulated under the Law for the time being in force;
- producing records and log of the consent, Information on authentication, identification, verification etc. as evidence before a court of law, any authority or in arbitration.

f) I,on my behalf and on behalf of all the persons proposed to be insured, hereby further authorize IFFCO-Tokio to share information pertaining to my proposal including the medical records of the person to be insured/ proposer for the sole purpose of underwriting the proposal and/or claims settlement with the Reinsurers/Co-Insurers, Regulatory and or Governmental Authorities/Court under the applicable laws, as may be required.

g) **I voluntarily submit my Aadhar Card/Aadhar Number(including Virtual ID, e-Aadhaar) for the purpose of KYC and I understand that it is not mandatory and alternative documents like Voter ID Card/ Passport/ Driving License/ NREGA Job card/ National Population Register Card can also be submitted for the purpose of KYC.

h) If after the insurance is affected, it is found that the statements, answers or particulars stated in the proposal form and its questionnaires are incorrect or untrue in any respect, the insurance company shall incur no liability under this insurance.

i) I have read the prospectus/sales literature and am willing to accept the coverage subject to the terms, conditions and exceptions prescribed by the insurance company therein. The policy Coverage and exclusions, Rates, terms & Conditions have been explained to me in my language and have been understood by me.

☐ I/We agree IFFCO-Tokio to call, send SMS, messages over internet-based messaging applications like WhatsApp and e-mail for services related to the product and to also offer additional insurance products and this consent is over and above any registration of the contact number on TRAI's National Do Not Call Registry

Date Signature of Proposer: Signature of the witness

Place: Name of Proposer: Name and address of the witness

NOTE: If answer to the question 4/5/6/7 is "Yes "or if you are above 50 years of age, please submit the Medical test reports as per the Company's guidelines

SECTION 41 OF THE INSURANCE ACT 1938

PROHIBITION OF REBATES

Payment of rebates is expressly prohibited under Section 41 of the Insurance Act, 1938.

1. No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take or renew 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 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 prospectus or tables of the Insurer. Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.
2. 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."

AGENT'S DECLARATION

I, _____(Full Name) in the capacity of Insurance Advisor/ Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained (in vernacular/local language as well) to the proposer all the contents of this Proposal Form including the nature of the question(s), statement(s), information and response(s) submitted by him/her. Any detail submitted through this proposal form will be considered as the basis of the Contract of Insurance between the Insurer and the Proposer, subject to the acceptance of the proposal. I have further explained that in case of any untrue statement(s)/information/misrepresentation is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to reject the proposal or limit benefits under the policy at its sole discretion. Also, in case of non-disclosure of any material fact, the policy issued to his/her favor based on the Proposal form may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited by the company.

Signature of the Advisor/Corporate Agent/Broker/Relationship Officer) _____

License No. and Agency Code/Broker Code/ Employee No. _____

Date: Place: Signature of Agent

ANNEXURE 1

Details of present/previous medical insurance like Individual or Group Mediclaim, Cancer Policy, Critical Illness or any other Policy for any of the Insured Person. (Please use additional sheets if required)

S. No.	Member 1	Member 2	Member 3	Member 4
Name of Insured Person				
Policy No.				
Name & Address of Insurance Co.				
Sum Insured				
Policy type (Individual/ Group Mediclaim/ Cancer Policy/ Critical Illness/ Any other)				
Period of Insurance				

ANNEXURE 2

Details of claims lodged under such Policies during last 4 years

S. No.	Name of Insured Person	Date of claim	Nature of claim	Amount of claim

ANNEXURE 3

Is any of the persons proposed for insurance receiving any treatment/ medication or has in past four years received treatment for any medical condition or disability? If YES, indicate details in the Table given below

S. No.	Name of Insured Person	Name of disease/injury suffering from	Treatment/medication received/receiving	Date first treated	Whether fully cured?

ANNEXURE 4

Have any of the persons proposed for insurance ever suffered from any of the diseases / illness particularly Cancer of specified severity, Myocardial Infarction (First Heart Attack of specific severity), Open Chest CABG, Open Heart Replacement Or Repair Of Heart Valves, Coma Of Specified Severity, Kidney Failure Requiring Regular Dialysis, Stroke Resulting In Permanent Symptoms, Major Organ /Bone Marrow Transplant, Permanent Paralysis Of Limbs, Motor Neuron disease with permanent symptoms, Multiple Sclerosis With Persisting Symptoms, Benign Brain Tumor, Blindness, Deafness, End Stage Lung Failure, End Stage Liver Disease, Loss of speech, Loss of Limbs, Major Head Trauma, Primary (Idiopathic) Pulmonary Hypertension, Third Degree Burns, Parkinson's disease before the age of 50, Alzheimer's disease before the age of 50, Muscular Dystrophy, Surgery of Aorta),.

S. No.	Name of Insured Person	Name of disease/injury suffering from	Treatment/medication received/receiving	Date first treated	Whether fully cured?

ANNEXURE 5

Medical History: Please answer the below mentioned questions Yes (Y) or No (N) ONLY:

Section A : Have any of the persons proposed to be insured ever suffered from/ are currently suffering from any of the following :	**Member Name**
i. Hypertension, chest pain, Ischemic heart disease or any other cardiac disorder	Yes☐No ☐
ii. Tuberculosis, asthma, bronchitis or any other lung/respiratory disorder	Yes☐No ☐
iii. Ulcer (stomach/duodenal), hepatitis, cirrhosis or any other Digestive or Liver/ Gallbladder disorder	Yes☐No ☐
iv. Renal failure, calculus or any other Kidney/Urinary tract or Prostate disorder	Yes☐No ☐
v. Dizziness, Stroke, Epilepsy, Paralysis or other brain/ nervous system disorder	Yes☐No ☐
vi. Diabetes, Thyroid disorder or any other endocrine disorder	Yes☐No ☐
vii. Tumor-benign or malignant, any ulcer/growth/cyst	Yes☐No ☐
viii. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint	Yes☐No ☐
ix. Diseases of the Nose/Ear/Throat/Teeth/ Eye (please mention Diopters)	Yes☐No ☐
x. HIV/AIDS or sexually transmitted diseases or any immune system disorder	Yes☐No ☐
xi. Anemia, Leukemia or any other blood/lymphatic system disorder	Yes☐No ☐
xii. Psychiatric/Mental illnesses or Sleep disorder	Yes☐No ☐
xiii. DUB, Fibroid, Cyst/Fibro adenoma or any other Gynecological/Breast disorder	Yes☐No ☐
Section B: Have any of the persons proposed to be insured:	

i. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy	Yes☐No ☐
ii. Been under any regular medication (self/ prescribed)	Yes☐No ☐
iii. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years	Yes☐No ☐
iv. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending	Yes☐No ☐
v. Suffered from any other disease/illness/accident/injury	Yes☐No ☐

If **YES** , Please provide all relevant details above,

S.No.	Name of the person to be insured	Name of disease/injury	Treatment/medication received /receiving	Date first treated	Whether fully cured?