IFFCO-TOKIO GENERAL INSURANCE
Muskurate Raho

IFFCO-TOKIO GENERAL INSURANCE COMPANY LIMITED

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

Website: www.iffcotokio.co.in | Toll Free No. 1800-103-5499

HEALTH PROTECTOR PLUS

(UIN: - IFFHLIP21328V022021)

PROPOSAL FORM

(URN: HPP/IFFHLIP21328V022021/PF-01)

PROPOSER DETAILS

Name				
Address				
City	State		Pin Code	
Email Address		Mobile No.		
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)				
☐ PAN No.	☐ AADHAR No.	☐ Any other(Please Specify)_____		
KYC Document Number				
Emergency Contact Person		**Emergency Contact No.**		

POLICY PERIOD, PLAN, SUM INSURED, DEDUCTIBLE

Cover Opted	**Top up**	☐	**Super Top up**	☐
Basis of Sum Insured	**Individual**	☐	**Family Floater**	☐
Waiver of deductible in case of loss / change of Job (fill details in annexure 1)				

DETAILS OF THE PERSONS TO BE INSURED:

Select the Sum Insured and Deductible from the below mentioned combination only.

Plan	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Sum Insured	200000	400000	500000	500000	750000	1000000	1500000	2500000
Deductible	100000	200000	200000	300000	300000	500000	500000	500000

DETAILS OF THE PERSONS TO BE INSURED

S.No.	**Member 1**	**Member 2**	**Member 3**
Name			
DOB (DD/MM/YY)			
Gender			
Height(Inches)			
Weight (Kgs)			
Plan Opted			
Relationship With The Proposer			
Occupation			
Sum Insured *			
Fresh / ITGI Renewal /Portability/ Migration(fill details in annexure 2)			

No. Of Years Of Continuous Coverage			
Have You Suffered From Any Disease/ Prolonged Ailment/ Disablement/ Suffered In Past (Please Mark As Yes/No)**			

DETAILS OF THE PERSONS TO BE INSURED

S.No.	Member 4	Member 5	Member 6
Name			
DOB (DD/MM/YY)			
Gender			
Height(Inches)			
Weight (Kgs)			
Plan Opted			
Relationship With The Proposer			
Occupation			
Sum Insured *			
Fresh / ITGI Renewal /Portability/ Migration(fill details in annexure 2)			
No. Of Years Of Continuous Coverage			
Have You Suffered From Any Disease/ Prolonged Ailment/ Disablement/ Suffered In Past (Please Mark As Yes/No)**			

(* For Floater Policy mention sum insured against the main member.)
(**please fill details in annexure 4)

Proposed Period of Insurance:	From		To	
(Subject to acceptance of proposal by Insurer and payment of premium before commencement of Risk).				
If it is ITGI Renewal, Whether there is change in Plan	**Yes** ☐	**No** ☐		
Have you lodged insurance claim in past (if yes fill details in annexure 3)	**Yes** ☐	**No** ☐		
Whether any Insurance company (including IFFCO TOKIO) has declined to accept the proposal of any of the members earlier?	**Yes** ☐	**No** ☐		
If **Yes,** please provide details. _____				

NOMINATION: In the event of death of the proposer, any payment due under the policy shall become payable to the nominee proposed in this form and the receipt of the proceeds by such nominee would be sufficient discharge to the Company. Nominee for all other persons proposed to be insured shall be the proposer himself/herself. The following section is to be filled by the proposer:

Nominee Name	Relationship	Address and Contact details of Nominee	%

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 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.
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, hereby declare and warrant that the above statements are true and complete. I agree that this proposal shall form the basis of the contract should the insurance be effected. 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 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.

Date _____ Signature of Proposer: _____ Signature of the witness

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

NOTE:

- Please fill in the proposal for carefully and answer all the questions honestly.
- **Please do not leave any question blank or write "-". This will only be construed as a "No" or "NIL" (or similar) declaration from the Insured**
- **Incorrect or non-disclosure of facts will make the contract void and all the benefits under the policy including the premium paid shall be forfeited.**
- People above **the specified** age should submit the prescribed test reports also along with proposal form. Please check with your agent for the details.
- Insurance Company reserves the right to seek additional information, diagnostic reports, Certificate from a doctor etc any time before the acceptance of the proposal / inception of cover.
- Company will reimburse 50% of the cost of prescribed tests, in case the proposal is accepted.
- Acceptance of the proposal is purely at the discretion of Insurance Company.
- Insurance company may accept the proposal at revised terms and / or rates. In such case the Insured reserves the right to decline before commencement of policy.
- Insured has a free-look period of 15 days from the inception of the policy subject to the guidelines of IRDA
- Submission of this proposal does not entail the proposer any rights. The liability of the insurer commences only after the proposal is accepted by the Insurer, payment of premium before commencement of risk and/or the date of inception of risk mentioned in the policy (whichever is later)

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

ADD PAYMENT DETAILS (*PLEASE FILL DETAILS IN ANNEXURE)

For Office Use Only	**SBU/LSC/BIMA KENDRA CODE:_____**
Checklist:	
Date of Acceptance:	_____
Medical Reports attachedYes No ☐ ☐	
Approving Authority (SBU/ Regional Office/ Corporate Office)	
Approval /E-mail Approval attached Yes ☐ No ☐	
Name of the Accepting Officer	**Signature of the Accepting Officer**

ANNEXURE 1:

If WOD is marked as yes, fill the table below:

DETAILS OF THE PERSONS TO BE INSURED

S. No.	Member 1	Member 2	Member 3	Member 4
Name of Insured Person				
Name of Employer				
DOJ				
Designation				
Sum Insured				
Address of Employer				
WOD Period Opted (30/60/90 Days)				

ANNEXURE 2:

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)

Name of Insured Person					
Policy No.					
Type of Policy (Group/Retail/Others)					
Name and address of					
Insurance Co.					
Sum Insured					
Period of Insurance	**To**				
	From				
Cumulative Bonus, if any					

Note: Please attach a photocopy of the expiring Policy or current Renewal Notice for Portability

ANNEXURE 3:

Details of Insurance claims lodged in the past. (Please use additional sheets if required)

S. No.	Name of Insured Person	Policy No	Date of claim	Nature and Description of claim	Amount of claim

ANNEXURE 4:

4.1 Have You Suffered from Any Disease/ Prolonged Ailment/ Disablement/ Suffered In Past, please provide following details:

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. High or low blood pressure	Yes ☐ No ☐
ii. Diabetes	Yes ☐ No ☐
iii. Chest pain, Ischemic heart disease or any other Heart disorder, Valve Related Disorder	Yes ☐ No ☐
iv. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint like ligament/ meniscus tear etc.	Yes ☐ No ☐
v. DUB, Fibroid, Cyst/Fibro adenoma or any other Gynaecological/Breast disorder	Yes ☐ No ☐
vi. Asthma / COPD or any other lung/Breathing disorder	Yes ☐ No ☐
vii. Tuberculosis	Yes ☐ No ☐
viii. Ulcer (stomach/duodenal), hepatitis, cirrhosis or any other Digestive or Liver/Gall bladder Disorder	Yes ☐ No ☐
ix. Renal failure, Kidney /ureteric stone or any other Kidney/Urinary tract or Prostate disorder	Yes ☐ No ☐

x. Dizziness, Stroke, Epilepsy(fits) , Paralysis or other brain/ nervous system disorder/ Multiple Sclerosis	Yes ☐ No ☐
xi. Thyroid disorder or any other endocrine disorder	Yes ☐ No ☐
xii. Tumor-benign or malignant, any ulcer/growth/cyst /mass or cancer	Yes ☐ No ☐
xiii. Diseases of the Nose/Ear/Throat/Teeth/ Eye (please mention Diopters for refractive errors	Yes ☐ No ☐
xiv. HIV/AIDS or sexually transmitted diseases or any immune system disorder	Yes ☐ No ☐
xv. Anaemia, Leukaemia or any other blood/lymphatic system disorder	Yes ☐ No ☐
xvi. Psychiatric/Mental illnesses or Sleep disorder	Yes ☐ No ☐
xvii. Any Congenital / Genetic disorders	Yes ☐ No ☐
xviii. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending	Yes ☐ No ☐
xix. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years	Yes ☐ No ☐
xx. Been under any regular medication (self/ prescribed)	Yes ☐ No ☐
xxi. Any other ailment / injury / sickness for which underwent treatment or undergoing/contemplating	Yes ☐ No ☐
xxii. Any type of organ transplanted	Yes ☐ No ☐

4.2 If your answer is YES, to any of the questions above, please provide details in the Table given below (Please use additional sheets if required)

S. No.	Name of the person to be insured	Name of disease/ injury	Treatment/medication received /receiving	Name of the Treating Doctor	Since When	Whether fully cured?

ANNEXURE 5:

PAYMENT DETAILS:					
Mode of payment.		☐ CHEQUE ☐ DD No. ☐ CREDIT CARD ☐ DEBIT CARD ☐ CASH			
Amount in figures		Amount in words_____			
Bank Name		Branch		City	
Cheque /DD No		Cheque/DD Date			
Name of Premium Payer		Relation to Proposer			
Credit/Debit Card Type:		☐ MASTER ☐ VISA ☐ AMERICAN EXPRESS ☐ OTHERS			
Credit/Debit Card No		Holder Name			
Expiry Date: DD/MM/YY:					

BANK DETAILS TO RECEIVE PAYMENT FROM INSURER			
Payee Name			
Account No.		IFSC/NEFT/RTGS Code:	
Bank Name:		Branch Address	

IFFCO-TOKIO GENERAL INSURANCE COMPANY LIMITED

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