IFFCO-TOKIO GENERAL INSURANCE CO. LTD

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

Website: www.iffcotokio.co.in **Toll Free No.18001035499**

Corona Kavach Policy, IFFCO-Tokio General Insurance Company Limited
UIN: **IFFHLIP21081V012021**
Proposal Form

1. Proposer Details

Proposer:Mr./Ms./Mrs																					DOB :		D	D	M	M	Y	Y
Address:																												
																					Pin Code:							
State:																			E Mail :									
Mobile:											Nationality:								GSTIN:									

2. Occupation

3. KYC Details (Please attach self-attested photo copies)
PAN No./ Aadhaar/ Any other :

4. 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	%

5. Policy Type:
a. Individual ☐ b. Family Floater ☐

6. Policy Period: ☐ 3 ½ months (Three & half months), ☐ 6 ½ months (Six & half months), ☐ 9 ½ months (Nine & half months)

7. Proposed Policy start date: _____
(Subject to acceptance of proposal by the Company and payment of premium before commencement of risk)

8. Details of the persons to be insured :

S. No.	Name	Relationship with the Proposer	Date of Birth (dd/mm/yy)	Gender (Male/ Female/ Third Gender)	Occupation	Geographies visited in last 3 months	Sum Insured** (Range : Rs 50,000 – Rs 5,00,000 in multiples of Rs 50,000)

** For Floater Policy mention sum insured against any one member

9. Optional Cover : Hospital Daily Cash required ? Yes ☐ No ☐

10. Details of any existing health insurance from IFFCO-Tokio General Insurance Co. Ltd
(Arogya Sanjeevani, Health Protector, Family Health Protector, Swasthya Kavach (Family Health) Policy, Swasthya Raksha Bima, Individual Medishield Insurance Policy, Group Medishield Insurance Policy)

S. No.	Name of Insured Person	Policy No.	Name of health insurance product	Sum Insured	Period of Insurance	
					From	To
1						
2						
3						
4						
5						
6						

11. Medical History: Please tick if the answer is YES:

Section A : Have any of the persons proposed to be insured ever suffered from/ are currently suffering from any of the following :	**Person proposed to be Insured**					
	1	2	3	4	5	6
i. High or low blood pressure						
ii. Diabetes						
iii. Chest pain, Ischemic heart disease or any other Heart disorder, Valve Related Disorder						
iv. Asthma / COPD or any other lung/Breathing disorder						
v. Tuberculosis						
vi. Renal failure, Kidney /ureteric stone or any other Kidney/Urinary tract or Prostate disorder						
vii. Thyroid disorder or any other endocrine disorder						
viii. Tumor-benign or malignant, any ulcer/growth/cyst /mass or cancer						
ix. Diseases of the Nose/Throat						
x. HIV/AIDS or sexually transmitted diseases or any immune system disorder						
xi. Anaemia, Leukaemia or any other blood/lymphatic system disorder						
xii. Any other ailment / injury / sickness for which underwent treatment or undergoing /contemplating						

12. 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?

13. Any additional facts which affect the proposed insurance & should be disclosed to the insurer.

(Please use additional sheets if required)

14. PAYMENT DETAILS: Mode of payment. --------------------- Cheque/ DD No./ Transaction ID …………………………
Bank ……………………………………… Date ……………………………… Rs. --------------------- (including Tax)

15. BANK DETAILS TO RECEIVE PAYMENT FROM INSURER:
Payee Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Account No. ____IFSC/NEFT/RTGS Code: ____________________
Bank Name: _______________________________________Branch Address_________________________________

DECLARATION

1. "I/We 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/We am/are 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.
3. I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the person to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
4. I/We declare and consent to the company seeking medical information from any doctor or hospital who 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 assured/proposer and seeking information from any insurance company 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/We 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."
6. 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.
7. 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.**
- 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.
- 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.
- 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/Authorised 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 favour 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

For Office Use Only **OFFICE CODE:** _____

Checklist:

1.	Date of Acceptance:	_____
2.	Medical Reports attached	Yes / No No of Reports ( )
3.	Approving Authority:	SBU/ Regional Office/ Corporate Office
4.	Approval /E-mail Approval attached	Yes / No Date of Approval _____