IFFCO-TOKIO GENERAL INSURANCE CO. LTD

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

HEALTH PROTECTOR ASSURE (HPA)

(UIN: IFFHLIP24131V012324)

PROPOSER DETAILS

Name					
Communication Address					
City		State		Pin Code	
Permanent Address (if different from the Communication address)					
City		State		Pin Code	
Email Address		Mobile No.			
PAN					

I want my policy related documents viz. Policy Schedule, Wordings etc. in:

Physical Format- Yes ☐ No ☐

e-Format (electronic) as & when applicable- Yes ☐ No ☐

☐ I have e Insurance Account & the No. is _____

☐ I am not having an e-insurance account & I authorize IFFCO-Tokio to open an e-insurance account.

Are You a Politically Exposed Person or related to PEP? {"Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials"}	☐ 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 ☐ PAN Card (mandatory where premium exceeds ₹ 10,000/-)
KYC Document Number/ CKYC Number	
To know Your CKYC No. Please give missed call on 7799022129	

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** ☐
Policy Period	1 Year ☐ 2 Year ☐ 3 Year ☐	
Frequency of Premium payment	Lumpsum: ☐	

Applicable for Policy Period 1 Year	Half-yearly: ☐ Quarterly: ☐ Monthly: ☐
Waiver of deductible in case of loss / change of Job (fill details in annexure 1)	
Wellness Benefit: (Applicable for Policy Period 1 year): (UIN: IFFHLIA22178V012122)	Yes: ☐ No: ☐
Consumable Protector: (UIN: IFFHLIA23152V012223)	Yes: ☐ No: ☐

SUM INSURED OPTIONS :

Essential Plan

Sum Insured	Deductible
300,000	200,000
	300,000
	500,000
	700,000
400,000	200,000
	300,000
	500,000
	700,000
500,000	200,000
	300,000
	500,000
	700,000
	1,000,000
	1,500,000
	2,000,000
	2,500,000
1,000,000	200,000
	300,000
	500,000
	700,000
	1,000,000
	1,500,000
	2,000,000
	2,500,000
	3,000,000
1,500,000	200,000
	300,000
	500,000
	700,000
	1,000,000
	1,500,000
	2,000,000
	2,500,000
	3,000,000

Sum Insured	Deductible
2,000,000	200,000
	300,000
	500,000
	700,000
	1,000,000
	1,500,000
	2,000,000
	2,500,000
	3,000,000
2,500,000	300,000
	500,000
	700,000
	1,000,000
	1,500,000
	2,000,000
	2,500,000
	3,000,000
3,000,000	500,000
	700,000
	1,000,000
	1,500,000
	2,000,000
	2,500,000
	3,000,000
4,000,000	500,000
	700,000
	1,000,000
	1,500,000
	2,000,000
	2,500,000
	3,000,000

Enhanced Plan

Sum Insured	Deductible
5,000,000	500,000
	700,000
	1,000,000
	1,500,000
	2,000,000
	2,500,000
	3,000,000
7,500,000	700,000
	1,000,000
	1,500,000
	2,000,000
	2,500,000
	3,000,000
10,000,000	1,000,000
	1,500,000
	2,000,000
	2,500,000
	3,000,000

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)			
Relationship With The Proposer			
Occupation			
Annual Sum Insured (Common for Family floater policy)			
Deductible (Common for Family floater policy)			
Fresh / ITGI Renewal /Portability/ Migration(please fill details in annexure 2)			
No. Of Years Of Continuous Coverage			
Date from which policy has been renewed continuously without break			
ABHA Number			
Mobile No. registered with Aadhar			
Have You Suffered From Any Disease/ Prolonged Ailment/ Disablement/ Suffered In Past (Please Mark As Yes/No) (# please fill details in annexure 4)			

S.no.	Member 4	Member 5	Member 6
Name			
DOB (DD/MM/YY)			

Gender			
Height (inches)			
Weight (KGs)			
Relationship With The Proposer			
Occupation			
Annual Sum Insured (Common for Family floater policy)			
Deductible (Common for Family floater policy)			
Fresh / ITGI Renewal /Portability/ Migration(please fill details in annexure 2)			
No. Of Years Of Continuous Coverage			
Date from which policy has been renewed continuously without break			
ABHA Number			
Mobile No. registered with Aadhar			
Have You Suffered From Any Disease/ Prolonged Ailment/ Disablement/ Suffered In Past (Please Mark As Yes/No (#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 Sum Insured / Deductible **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. _____				

Select the Co-pay option required: |___| Not required |___| 10% |___|20% |___| 25%
Do you hold any other policy from IFFCO-Tokio? If yes, kindly provide policy no._____
Are you covered in any Group Mediclaim policy insured by IFFCO-Tokio? If yes, kindly provide policy no.
Are you an employee of IFFCO-Tokio? _____

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. If only one nominee is mentioned insurer will consider his/her share as 100%.
The following section is to be filled by the proposer:

Description	**Nominee 1**	**Nominee 2**	**Nominee 3**
Name of Nominee			
Relationship with Proposer			
Communication Address			
Permanent Address (if different from the Communication address)			
E-mail ID			
Phone No.			
Percentage (%)			
Bank Account Details Account Number IFSC			
Guardian Details (if Nominee is minor) Name of Guardian: Address: Phone No:			

BANK ACCOUNT DETAILS FOR REUND/SETTLEMENT OF CLAIM:

All settlements for Refund/Claims shall be made in my bank account whose details are provided below

Note: Please provide the following bank details and a copy of Cancelled Cheque for direct credit of refund/ claim into your bank account:(Cancelled Cheque should be of the same bank account in which the refund/ claim proceeds need to be credited directly. Name as per Bank Account and name of the Proposer shall match and details of third party Bank Account shall not be provided.)

Name of Accountholder	
Bank Name	
Branch Name	
Bank Account No	
IFSC Code	

Please go through all the policy related documents carefully including customer information sheet, policy wordings, policy schedule, prospectus.

DECLARATION

a) I/we have read the prospectus/sales literature and am/are willing to accept the coverage subject to the terms, conditions and exceptions prescribed by IFFCO-Tokio therein. The policy Coverage, Rates, terms & Conditions have been explained to me/us in my language and have been understood by me/us.

b) I/we hereby declare and warrant that the above statements are true and complete in all respects and that there is no other information, which is relevant to my/our application for insurance that has not been disclosed to you. I agree that this proposal and the declaration shall be the basis of the contract between me and IFFCO TOKIO GENERAL INSURANCE CO LTD and I agree to accept a policy, subject to the conditions prescribed by IFFCO TOKIO GENERAL INSURANCE CO LTD. I further certify that the replies in the Proposal Form have been recorded as per the information provided Proposal Form by me.

c) I/we agree that the Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect statement, misrepresentation, non- description or non-disclosure of material particulars in the Proposal Form/ personal statement, declaration and connected documents, or any material fact*/ information has been withheld by beneficiary.

*A material fact will mean and include all important, essential and relevant information, pertaining to the questions made in this proposal form, that are likely to influence company's acceptance or assessment of the proposal.

d) 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.

e) 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.

f) 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.

g) 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.

h) 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.

i) 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 evaluating and underwriting the proposal and issuing insurance policy and/or claims settlement with the Surveyors/ Investigators, Reinsurers/Co-Insurers, Regulatory and or Governmental Authorities/Court under the applicable laws, as may be required for effective discharge of obligations as an Insurer and I understand that this proposal form is a valid consent from my side for sharing my personal data with above named third parties in connections or furtherance of this policy/claim.

j) ** I am submitting my Aadhar Card/Aadhar Number (including Virtual ID, e-Aadhaar) voluntarily for KYC and I understand that use of Aadhaar is not mandatory and alternative documents like Voter ID Card/ Passport/ Driving License/ NREGA Job card/ National Population Register Card/ CKYC Number may also be submitted for KYC. I hereby further authorize IFFCO-TOKIO to download/update/upload my particulars from/to CKYC Registry, based on CKYC no./ Other KYC documents provided by me.

k) I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

l) 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.

m) I/ We hereby confirm that all premiums have been/ will be paid from bonafide sources and no premiums have been/ will be paid out of proceeds of crime related to any of the offence listed in Prevention of Money Laundering Act 2002. I/We understand that the Company has the right to call for documents to establish source of funds. The insurance Company has the right to cancel the insurance contract in case I am/ have been found guilty by any competent court of law under any statues, directly or indirectly governing the prevention of money laundering in India.

☐ **n)** I agree IFFCO-Tokio to call, and 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.

☐ **o) I / we do not have any existing ABHA ID and I/we hereby give consent to IFFCO-TOKIO to facilitate to create Ayushman Bharat Health Account (ABHA) Number for me/us insured under the Policy.**

p) **Vernacular/Disability Declaration**

Applicable where the Proposer is illiterate or is suffering from a disability due to which writing is restricted or where the Proposer has signed in vernacular language. (Note: The below consent must be witnessed by someone other than the Agent/ Intermediary/Employee of the Company).

I/We certify that the product applied by me/us and the contents of the Proposal Form have been clearly explained to me/us and I/We have fully understood them. I/We further certify that the replies in the Proposal Form have been recorded as per the information provided by me/us.

I, _____(Full name of the witness), _____(Relation with the Proposer) adult and inhabitant of (city) and residing at_____ do hereby certify that I have read out and explained the contents of the Proposal Form and all other documents incidental to availing the insurance policy from IFFCO-TOKIO General Insurance Co. Ltd.., to the Proposer and he/she/they have understood the same. I/we declare that whatever I/we have stated herein above is true and correct to the best of knowledge and belief.

Date _____ Signature/Thumb Impression 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.
- 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 30 days from the inception of the policy subject to the guidelines of IRDAI.
- Submission of this proposal does not entail the proposer any rights. Our liability commences only after the proposal is accepted by Us, 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.
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 ATTACHED ANNEXURE 5)

For Office Use Only	**SBU/LSC/BIMA KENDRA CODE:** _____
Checklist:	
Date of Acceptance:	_____
Medical Reports attached Yes☐ 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 Waiver of Deductible is marked as **yes**, fill the table below:

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

*If required p*lease use additional sheet for other members details*

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:

1. Please attach a photocopy of the expiring Policy or current Renewal Notice for Portability

*2. If you are covered under IFFCO-Tokio's Family Health Protector, Health Protector or Group Medishield Insurance Policy, kindly provide past 4 years' policy no.

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:

Please tick against the relevant insured 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 :	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. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint like ligament/meniscus tear etc						
v. DUB, Fibroid, Cyst/Fibroadenoma or any other Gynaecological/Breast disorder						
vi. Asthma / COPD or any other lung/Breathing disorder						
vii. Tuberculosis						
viii. Ulcer (stomach/duodenal), hepatitis, cirrhosis or any other Digestive or Liver/Gallbladder Disorder						
ix. Renal failure, Kidney /ureteric stone or any other Kidney/Urinary tract or Prostate disorder						
x. Dizziness, Stroke, Epilepsy(fits) , Paralysis or other brain/ nervous system disorder/ Multiple Sclerosis						
xi. Thyroid disorder or any other endocrine disorder						
xii. Tumor-benign or malignant, any ulcer/growth/cyst /mass or cancer						
xiii. Diseases of the Nose/Ear/Throat/Teeth/ Eye (please mention Diopters for refractive errors						
xiv. HIV/AIDS or sexually transmitted diseases or any immune system disorder						
xv. Anaemia, Leukaemia or any other blood/lymphatic system disorder						

xvi. Psychiatric/Mental illnesses or Sleep disorder						
xvii. Any Congenital / Genetic disorders						
xviii. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending						
xix. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years						
xx. Been under any regular medication (self/ prescribed)						
xxi. Any other ailment / injury / sickness for which underwent treatment or undergoing /contemplating						
xxii. Any type of organ transplanted						

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

No.	Name of Insured Person	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	