

COMMON PROPOSAL FORM

	HEALTH TOTAL	ADVANTAGE TOP- UP	HEALTH SURAKSHA	ACCIDENT SURAKSHA
IO / Win No				
App No				
Client Code				
Receipt No				
Payer ID				
SB/CA Acc No				
Journal no/ Bank name				

IMPORTANT GUIDELINES:

- 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.
- Please answer all questions carefully. Any incomplete, incorrect or partially correct answers may lead to rejection of the proposal and also might lead to cancelation of policy.
- It is important to fill all questions, information for fields marked with asterisk [*] is mandatory.
- 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: _____

DESIRED PERIOD OF INSURANCE*:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

1. PROPOSER DETAILS*:

Name of the Proposer*	 Sur Name First Name Middle Name		
Full Address*			
State		Pin code*	
Contact Number*	Landline:	Mobile:*	
Email Id*			
Date of Birth*	DD / MM / YYYY	Gender*	☐ Male ☐ Female ☐ Third Gender
PAN		Aadhaar Number	
Note: PAN is mandatory where the premium exceeds Rs. 50,000/- in cash and where premium exceeds Rs. One Lakh in any mode.			
e-IA Number (e-Insurance Account)			

Number)	<i>If not available request you to kindly download the form from our website and request you to kindly submit along with this proposal form</i>			
Marital Status*	☐ Married	☐ Single	☐ Widow/Widower	☐ Divorced
Nationality*				
Occupation	☐ Service	☐ Self Employed	☐ Others: _____	
Are you an existing Generali Central customer*? If yes, please provide: Existing Policy No.: _____ Customer ID No.: _____				☐ Yes ☐ No

2. PRODUCT OPTION* (please tick the product opted) :-

☐ Health Total UIN: GCIHLIP25037V062425	☐ Advantage Top Up UIN: GCIHLIP23053V032223	☐ Health Suraksha UIN: GCIHLIP25017V052425	☐ Accident Suraksha UIN: GCIPAIP18040V021718
--	--	---	---

(Refer respective product brochures for details)

3. DETAILS OF INSURED*

Sr. No	Name on insured	Gender	Date of birth	ABHA No.^^	Relationship with proposer	Height	Weight	Occupation#	Income per Annum # (if applicable)	Nominee name\$	Relationship of nominee with insured\$
1											
2											
3											
4											

For Accident Suraksha policy- Income declaration and occupation is mandatory.

\$ Nominee for Primary insured/ Proposer may to be among the following mentioned relations- Father / Mother / Son / Daughter / Spouse.

^^Please provide ABHA number (Ayushman Bharat Health Account number) for all the proposed Insured Persons. In case the ABHA number is not available for any Insured Person, you may request to create an ABHA number by visiting the web link: <https://healthid.ndhm.gov.in/register> Please note for members other than Primary insured/Proposer 100% nomination shall be to the proposer only. If more than one person to be nominated then please fill details in the below table -

Name	Nominee **	Name of Nominee	DOB/Age	Relation **	% of Sum Insured
Primary insured/ Proposer	Nominee 1				
	Nominee 2				
	Nominee 3				
	Nominee 4				

In case the nominee is a minor then please provide the name and address of the Appointee.

Name and address of the Appointee	
Relationship with the Nominee	

4. Health Details* (Please answer as “Yes” or “No” against each of the questions. A mere dash is not sufficient.)

Questions	A	B	C	D	E	F
Insured Name	Are all persons to be insured currently in good health and free from physical and mental disease or illness or medical complaints or disability?	Does any person to be insured regularly smoke Tobacco? Or consume alcohol -If yes, please mention – quantity / day, number of years since (consuming/ smoking / or alcohol)	Does any person to be insured, suffer or has suffered from any health complaints, signs or symptoms, or were taking treatment or were hospitalized for any illness in the past? If ‘yes’, give details and duration since when?	Has any person to be insured, at present or in the past, met with an accident/ injury or was hospitalized or taking treatment for any accidental injury, or has any disability?	Has any person to be insured, undergone any surgery in the past or is going for any planned surgery at present/ recent /future?	Are all persons to be insured, fully cured? (Yes /No) - Applicable only if any of the question from C to E are answered “YES”
Self						
Spouse						
Child 1						
Child 2						

5. Please confirm if any of the persons to be insured is pregnant (applicable for females only) Yes ☐ No ☐

6. Other ongoing Health insurance / Personal accident / Critical illness policy information*

Name of insured	Policy No.	Name and Address of insurance company	Sum Insured	Period of insurance (first inception date - dd/mm/yy)	From: dd/mm/yy to: dd/mm/yy	Claim details, claim amount received or receivable (in ₹)	Are any persons to be insured opting for portability or migration from an existing cover? please mention in YES or NO
Self							
Spouse							
Child 1							
Child 2							

Note: - In case of Portability/ Migration, kindly fill Portability/ Migration Request form along with this form.

7. Loyalty discount -

a. Loyalty discount is applicable under Health Suraksha and Advantage Top-up Policies.

- b. Loyalty discount is applicable incase the insured already has a separate Retail health insurance policy from Generali Central Insurance Co. Ltd. other than same Health product / Personal Accident/ Travel products.
- c. Loyalty discount shall continue only if the insured maintains the separate health insurance policy with us. Please provide the complete details in Section 6 above along with the policy copy to avail the discount.

8. Attach age proof document for each insured. (Please tick whichever is applicable) ☐ Passport ☐ PAN Card
☐ Driving license ☐ Others, please specify

9. Product section – (fill only those product details which proposer want to opt)

- For Individual Plan- kindly indicate the plan and sum insured details for all the Members to be covered.
 - For Family Floater Plan -The plan option and sum insured will float over the family members covered under the Policy.
 - In case of instalments required please select from the below options
 - ☐ ACH (Duly filled and signed single ACH form to be submitted for instalment option along with Proposal form. In case instalment option selected is different for respective products chosen then separate ACH form to be submitted) ☐ E-Mandate/E-NACH# (Please provide Bank Name*)
- # Link will be sent to the registered mobile number mentioned in the proposal form for activating E –Mandate/ E–NACH. If the same is not activated, the Subsequent instalment will not be debited and risk will not be covered. The updated list of eligible Banks for E-Mandate/E-NACH is available under National Payments Corporation of India (NPCI) website <https://www.npci.org.in>

A. HEALTH TOTAL

- Policy term* (please tick the term opted)** : ☐ 1 Year ☐ 2 Years ☐ 3 Years
- Policy type** : ☐ Floater ☐ Individual
- Instalment Option***: If policy term more than one year, instalment option is available. Please tick any one option you want to opt for: ☐ Monthly ☐ Quarterly ☐ Half yearly.
- Plan options available**: Vital Plan, Superior Plan, Premiere Plan

Please provide coverage details in below table (Please do not fill anything in Premium Computation Column):

Insured Name	Individual sum insured option			Floater sum insured options			Premium computation individual or floater (for office use only)	Final Premium inclusive of GST*)
	Plan	Sum insured (₹)	Voluntary Deductible (₹)^	Plan	Sum insured (₹)	Voluntary Deductible (₹)^		
Self								
Spouse								
Child 1								
Child 2								

^Note: - Please refer product brochure for details of voluntary deductible discounts.

B. ADVANTAGE TOP- UP –

- Policy term* (please tick the term opted)** : ☐ 1 Year ☐ 2 Years ☐ 3 Years

- **Policy type** : ☐ Floater ☐ Individual
- **Instalment Option*:** *: If policy term more than one year, instalment option is available. Please tick any one option you want to opt for:
☐ Monthly ☐ Quarterly ☐ Half yearly.
- **Plan options available:**
Supreme Plan – includes cover for all ailments including Heart related conditions and Cancer.
Elite Plan – includes cover only for Cancer and ailments related to Heart. A discount of 30% shall be applicable in case Elite plan is opted.

Please provide coverage details in below table (Please do not fill anything in Premium Computation Column):

Insured Name	Individual sum insured option			Floater sum insurance option			Premium computation individual or floater (for office use only)	Final Premium inclusive of GST *
	Plan	Sum Insured (₹)	Deductible (₹)^	Plan	Sum Insured (₹)	Deductible (₹)^		
Self								
Spouse								
Child 1								
Child 2								

^Note: - Please refer product brochure for details of deductible options.

C. HEALTH SURAKSHA:-

- **Policy term* (please tick the term opted)** : ☐ 1 Year ☐ 2 Years ☐ 3 Years
- **Policy type** : ☐ Floater ☐ Individual
- **Instalment Option*:** If policy term more than one year, instalment option is available. Please tick any one option you want to opt for:
☐ Monthly ☐ Quarterly ☐ Half yearly

Please provide coverage details in below table (Please do not fill anything in Premium Computation Column): all figures in INR

Details	Self	Spouse	Child 1	Child 2
Plan/ Sum Insured options (Individual)	☐ 100000 ☐ 150000\$ ☐ 200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐ 450000 ☐ 500000	☐ 100000 ☐ 150000 ☐ 200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐ 450000 ☐ 500000	☐ 50000** ☐ 100000** ☐ 150000** ☐ 200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐ 450000 ☐ 500000	☐ 50000** ☐ 100000** ☐ 150000** ☐ 200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐ 450000 ☐ 500000

	Topaz Plan	☐ 100000** ☐ 200000 ☐ 300000 ☐ 400000 ☐ 500000	☐ 100000** ☐ 200000 ☐ 300000 ☐ 400000 ☐ 500000	☐ 100000** ☐ 200000 ☐ 300000 ☐ 400000 ☐ 500000	☐ 100000** ☐ 200000 ☐ 300000 ☐ 400000 ☐ 500000
	Platinum Plan	☐ 600000 ☐ 750000 ☐ 800000 ☐ 900000 ☐ 1000000	☐ 600000 ☐ 750000 ☐ 800000 ☐ 900000 ☐ 1000000	☐ 600000 ☐ 750000 ☐ 800000 ☐ 900000 ☐ 1000000	☐ 600000 ☐ 750000 ☐ 800000 ☐ 900000 ☐ 1000000
	Ruby Plan	☐ 600000 ☐ 750000 ☐ 1000000	☐ 600000 ☐ 750000 ☐ 1000000	☐ 600000 ☐ 750000 ☐ 1000000	☐ 600000 ☐ 750000 ☐ 1000000
Plan/ Sum Insured option (Family Floater)	Gold Plan	☐ 200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐ 450000 ☐ 500000			
	Topaz Plan	☐ 200000 ☐ 300000 ☐ 400000 ☐ 500000			
	Platinum Plan	☐ 600000 ☐ 750000 ☐ 800000 ☐ 900000 ☐ 1000000			
	Ruby Plan	☐ 600000 ☐ 750000 ☐ 1000000			
Premium computation## (for office use only)					
Premium (including GST)					

The premiums for respective Zones will be based on Proposer's residence/ pin code/ zone. Please note the Cities/ Towns that fall under respective Zones shall be identified as per the updated/ latest Jurisdiction defined.

**Sum insured of ₹ 50000, 100000, 150000 for Zone A/ Zone B/ Zone C will be available for Children up to age of 25 years

Premium for floater will be as per the age of the eldest member

D. ACCIDENT SURAKSHA :-

- **Policy term* (please tick the term opted) :** ☐ 1 Year ☐ 2 Years ☐ 3 Years
- **Policy type - Individual only**
- Mandatory details in case Loan Protector Cover and Child Education Support covers are opted:
 - i. Do you have a child / children?* ☐ Yes ☐ No
 - ii. Do you or your family member to be insured have any Loan from Financial organization?* ☐ Yes ☐ No

Please provide coverage details in below table (Please do not fill anything in Premium Computation Column):

Coverage's & Sum insured#	Self	Spouse	First Child	Second Child
	PRIMARY COVERS			
Accidental Death				
Permanent Partial disablement				

Permanent Total disablement				
Temporary Total disablement				
	ADDITIONAL COVERS - Following cover may be opted on payment of additional premium			
Child Education Support				
Life Support Benefit				
Accidental Medical Expenses				
Accidental Hospitalisation				
Hospital Cash Allowance				
** Loan Protector				
Adaptation Allowance				
Family Transportation Allowance				
Broken Bones				
Road Ambulance cover				
Air Ambulance cover				
Adventure Sports Benefit				
Chauffer plan Benefit				
Gross Premium				
Gross Premium +GST				

--	--	--	--	--

** Loan Protector Benefit cover should be opted, if applicable. # Repatriation of remains and Funeral benefit is an inbuilt cover.

PAYMENT DETAILS*

Premium paid by Cash/ Cheque No		Date:	DD	MM	YYYY
Bank Name		Amount ((₹):			
Amount (in words)					
GSTIN (If more than one GSTIN, kindly attach an annexure with details)	PAN (if premium is 1 Lac and above.) -				
<i>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. It is necessary where the premium is more than ₹10,000/-.</i>					

10. DECLARATION

- 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.
- 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.
- 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.
- 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.
- 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, further, declare and warrant that:
 - There is no other material/relevant information, that has not been disclosed to GCICL and if any information given in this proposal is found to be untrue, the insurance policy shall be void ab initio and the premium shall be forfeited to GCICL.
 - I agree to receive service related information from GCICL, and its service providers, through electronic and telecom modes, including WhatsApp, can be sent to me and understand that no unsolicited information will be sent to me.
 - The information/data provided by me, through this application, to GCICL and/ or GCICL authorised person/ agency, shall be stored by GCICL, throughout the currency of my relationship with GCICL, and used for the purposes relating to my proposal for insurance cover and/or servicing policies issued in my favour, whether by GCICL or its authorized partners. I also understand that the said storage is necessary for my consumption of the services and consent to not hold GCICL and/or its authorized partners/ agency/ person liable for legitimate utilization of the submitted information/data.

7. I declare that the premium amount, corresponding to this proposal, is paid out of the legally declared and assessed sources of my income and not out of proceeds of crime related to any offence under the Prevention of Money Laundering Act, 2002 and rules framed thereunder. I understand that GCICL reserves the right to call for documents and information to establish the source of funds, as also the right to reject the said proposal or to terminate the insurance contract unilaterally and/or forfeit the premium amount, if I am found to be named in any recognized sanction list/happen to have violated any provisions of law. OR
I confirm that the premium has been paid by _____, who has an insurable interest in my policy and refund, if any, shall be processed in my bank account.
8. I am (please tick all that are applicable) ☐ HNI ☐ NRI ☐ Politically Exposed Person ☐ Jeweller ☐ NGO ☐ Film Actor ☐ Producer ☐ Others.
9. **ABHA Declaration (Applicable only if you have shared the ABHA number with Us)** - I, hereby declare that I am voluntarily sharing Ayushma Bharat Health Account number (ABHA No) for the proposed Insured Persons, with Generali Central Insurance Company Limited, for the sole purpose of accessing my records of medical history, which will be used to verify/share relevant information provided herein on confidential basis within its Group and /or third party agencies in connection with the Claims, for the purpose of facilitating insurance/ reinsurance services and ancillary services.
10. I consent to the fact that GCI may download my/proposer's CKYC record from the Central KYC Records Registry, in relation to the verification of my/proposer's KYC records as part of this proposal. I understand that acceptable officially valid documents shall be relied upon for the said verification of KYC records. I, also, consent to receive information from the Central KYC Registry through SMS/email on the above-mentioned mobile phone number/email address.
It is, also, confirmed that the KYC records available in the CKYC Registry are current and valid, as on the date of this proposal, and can be used by GCI hereafter. In case of any modification, the applicable information will be provided to GCI for updating the CKYC Registry Records.
11. **"Bima – ASBA Declaration (Please tick the box if you want to utilize the Bima-ASBA facility)**
☐ I hereby accord my consent to authorize Generali Central Insurance Company Limited to block the applicable premium payable for the aforesaid insurance policy under the BIMAASBA facility and debit the same from my bank account upon acceptance of this proposal. In case the proposal is not accepted, I accord my consent to debit only the expenses incurred towards medical examination, if any, and unblock the balance amount"

Optional Declaration

I/We hereby give my/our consent to the Company to use my/our personal information for quality and data analysis purpose which may be carried out by an empanelled third party vendor ☐ Yes / ☐ No

*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://generalicentralinsurance.com/>)*

Date: DD / MM / YYYY Place:

Proposer's Name:

Proposer's Signature/ Thumb Impression:

For use by Intermediary Only

I, _____, in my capacity as an Insurance Agent/POSP/Specified Person of the Corporate Agent/Authorized Person of the Broker/IMF, declare that I have explained the product features, including its suitability, and the contents of this proposal form, including the nature of the questions and the responses submitted thereto, to the proposer. It has been, further, informed to the proposer that the details provided herein shall form the basis of the contract of insurance between GCICL and the proposer. It has, also, been explained that if any

untrue response(s) is/are contained in this proposal form or there has been any non-disclosure of material facts, the policy issued thereon shall, at the option of GCICL, be treated as null and void and the premium amount against the policy may be forfeited by GCICL.

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 language other than English/or is not literate)

**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 affixed the thumb impression above after fully understanding the content thereof.

Witness Name:	Intermediary / Agent Name:
Witness Signature:	Intermediary / Agent Signature:
POSP Name:	POSP Code:
POSP PAN No.:	Date and place :

12. FOR OFFICE USE ONLY

Intermediary Name:	Intermediary Code:
Sales Manager Name:	Sales Manager 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 liable for a penalty which may extend to Ten Lakh Rupees.



Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office: Unit No. 801 & 802, 8th Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | IRDAI Regn. No.:132| CIN: U66030MH2006PLC165287 | Website: www.generalicentralinsurance.com | Email ID: gcicare@generalicentral.com | Toll-free Phone: 1800 220 233 / 1860 500 3333/ 022 6783 7800