GENERALI Central INSURANCE

IO No	
App No	
Client Code	
Receipt No	
Payer ID	
SB/CA Acc No	
Journal no/ Bank name	

CRITICARE PROPOSAL FORM

IMPORTANT GUIDELINES:

1. 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.
2. 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
3. It is important to fill all questions, Information for fields marked with asterisk [*] is mandatory.
4. Cover shall commence not earlier than the date and thetime of acceptance and subsequent to payment of the premium.

Received Date: _____ **Branch Code:** _____ **Branch Name:** _____

Period of Insurance desired: From: dd/mm/ yyyy **To** dd/mm/ yyyy

SECTION I: DETAILS OF THE INSURED/ PROPOSER

1. PROPOSER DETAILS*: Name: ☐ Mr. ☐ Ms. ☐ M/s

2. PERMANENT ADDRESS AND OTHER DETAILS:

State		**Pin code**	
Telephone no.*		**Mobile no*.**	
Email id*		**Residential Status**	

PRESENT ADDRESS (IF SAME AS ABOVE, PLEASE TICK ☐)

State			
		Pin code	
PAN		***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	*If not available request you to kindly download the form from our website and request you to kindly submit along with this proposal form*		

4. GENDER*: ☐ Male ☐ Female ☐ Third Gender

5. DATE OF BIRTH*: ____/ _____/

6. PLEASE PROVIDE COPY OF ANY OF THE FOLLOWING AS PROOF OF AGE*:
☐ Passport ☐ Birth Certificate ☐ Domicile Certificate ☐ School or College Certificate ☐ Others

7. MARITAL STATUS*: ☐ Married ☐ Single ☐ Widow ☐ Divorced

8. EDUCATIONAL QUALIFICATION:

9. NATIONALITY*: _____

10. RESIDENTIAL STATUS: _____

11. OCCUPATION*: ☐ **Service** ☐ **Self Employed** ☐ **Others:**

12. ORGANISATION: _____

13. If you are Differently Abled, please tick mark on the checkbox to provide confirmation. ☐

If yes, kindly provide the below details	
Type of Impairment	
Percentage of Impairment	
UDID Number	

SECTION II A: DETAILS OF INSURED

TYPE OF POLICY: ☐ INDIVIDUAL ☐ FAMILY FLOATER

Sr. No	Name	Gender	Date of Birth	ABHA No^^	Relationship with proposer	Ht	Wt	Nominee name**	Sum Insured Opted for Individual Policy	Sum Insured Opted for Family Floater Policy	Premium Computation

1	Primary Insured				Self						
2											
3											
4											
5											
6											
	Total Premium including Goods & Services Tax.										

NOMINEE DETAILS

In case the Policyholder (Presently, proposer) dies, payments due under the policy that may be issued shall be payable to the credit of the nominees identified through this proposal. Nominee(s) for the proposal shall, preferably, be an immediate relative of the Proposer. Vide insurable interest of the proposer in the other persons proposed to be insured, the proposer is construed as nominee for such other persons, unless differently advised.

Sr No	Particulars	Nominee 1	Nominee 2	Nominee 3	Nominee 4
1	Name				
2	Age				
3	Mobile No.				
4	Email ID				
5	Present Address				
6	Permanent Address (If same as above, please tick here) ☐				
7	Relationship with the Proposer				
8	Specify the Percentage (%) of Claim amount payable to each nominee in the event of the policyholder's death. The total percentage of contribution across all the nominee(s) must not exceed 100%				
9	Bank details of the nominee				
9.a	Account No.				
9.b	IFSC/MICR Code				
9.c	Name of the Bank				
9.d	Account Holder Name				

Appointee Details (Required only if the nominee is a minor)

Sr No	Particulars	Appointee 1	Appointee 2	Appointee 3	Appointee 4
1	Name				
2	Age				
3	Mobile No.				
4	Email ID				
5	Present Address				
6	Permanent Address (If same as above, please tick here) ☐				
7	Relationship with Appointee				
8	Specify the Percentage (%) of Claim amount payable to each nominee in the event of the				

	policyholder's death. The total percentage of contribution across all the nominee(s) must not exceed 100%				
9	Bank details of the Appointee				
9.a	Account No.				
9.b	IFSC/MICR Code				
9.c	Name of the Bank				
9.d	Account Holder Name				

**In case the nominee is minor, please mention the name of the appointee. *Family means and includes You, Your Spouse, Your first two dependent children and your two dependent parents. At any point of time the family floater cannot exceed for more than 6 members*

^^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

B. FAMILY HISTORY OF INSURED*:

	Primary Insured	Spouse	Father	Mother	Child 1	Child 2
Father	Current Age/ Age atdeath	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death
	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death
Mother	Current Age/ Age atdeath	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death
	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death
Sibling 1	Current Age/ Age atdeath	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death
	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death
Sibling 2	Current Age/ Age atdeath	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death
	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death
Sibling 3	Current Age/ Age atdeath	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death	Current Age/ Age at death
	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death	Current health status/ Cause of Death

C. LIFESTYLE DETAILS OF INSURED*: *(Please answer by ticking either "yes" or "no" against each of the questions)*

Sr. No.	Question	Primary Insured		Spouse		Father		Mother		Child 1		Child 2	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	Is your occupation associated with any specific hazard (e.g. chemical factory, mines, explosives, radiation, corrosive chemicals etc)?												
2	Are you employed in the armed, Paramilitary or police forces?												
3	Do you take part in activities or have hobbies that could be dangerous in any way?												
4	Do you consume or have ever consumed Tobacco, Alcohol or any Narcotic? (If yes, specify the details separately in the format below)												

Substance	Quantity/ day	No of years since consuming
Tobacco		

Alcohol		
Narcotic		

D. HEALTH QUESTIONS*: *(Please answer by ticking either "yes" or "no" against each of the questions)*

Sr. No.	Question	Primary Insured		Spouse		Father		Mother		Child 1		Child 2	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1.	Are you presently in a good health and fully functioning with work, school or home life and entirely free from any mental or physical impairments or deformities?												
2.	Do you have any physical deformity/ handicap or use any mechanical/ physical assistance for mobility?												
3.	Have you ever consulted any doctor or are you currently undergoing any tests, investigations, awaiting results of any tests or investigations or have you ever been advised to undergo any tests, investigations or surgery or been hospitalized for general checkup, Observation, Treatment or Surgery?												
4.	Did you have any Ailment/ Injury/ Accident requiring Treatment/ Medication for more than a week?												
5.	Are you at present or at any time in past on any medication, special diet or treatment?												
6.	Were you or your spouse ever tested for Hepatitis B or C, HIV/AIDS or any other Sexually Transmitted Disease or have you ever been refused as a blood donor?												
7.	Have you undergone/ have been recommended to undergo any of the following- Angioplasty, Bypass Surgery, Brain surgery, Heart valve surgery, Aorta surgery or organ transplant or any other major Surgery or Treatment												
8.	**Have you ever suffered or are suffering from any of the following**												
(a)	Disease of the circulatory system (e.g. heart trouble, chest pain, rheumatic fever, high blood pressure, diseases of the arteries and veins)?												
(b)	Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia or emphysema)?												
(c)	Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)?												
(d)	Diseases of the gastrointestinal system (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B, hepatitis C or other disorders of the												
Sr. No.	**Question**	**Primary Insured**		**Spouse**		**Father**		**Mother**		**Child 1**		**Child 2**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
(e)	Diseases of the nervous system or mental disorders (e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown, depression or other mental or psychiatric disorder)?												
(f)	Diabetes mellitus, cancer or tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes or skin?												

(g)	Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands?												
(h)	Ailments related to Liver, Reproductive System												
(i)	Anemia, blood or blood related disorders												
(j)	Musculoskeletal disorders such as Arthritis, recurrent back pain, slipped disc or any other disorder of Spine, Joints or Limbs or Leprosy												
(k)	Chest pain, Palpitation, Rheumatic fever, heart murmur, heart attack, shortness of breath or any other heart related disorder												
(l)	Thyroid disorder or any other disease or disorder of the Endocrine system												
(m)	Any other diseases or ailments not mentioned above?												

E. QUESTIONS TO BE ANSWERED BY FEMALE INSUREDS* *(Strike off for all Male Insured)*

9.	Have you ever suffered /are you suffering from Gynecological Problems?												
10	Are you Pregnant at present? (i) If yes, mention the duration in weeks												
	(ii) Any complications, miscarriage, medical termination of pregnancy or Caesarian?												
11	Have you ever undergone any investigation or treatment or received medical advice or consulted a physician for:												
	(i) Any disease or disorder of the Cervix, Uterus, Ovary (ies) or Vagina, abnormal bleeding, Cancer or abnormal growth?												
	(ii) Any disease or disorder of the Breast(s) such as Breast Lump/cyst, Fibrocystic disease, Nipple changes or discharge, cancer or growth?												
	(iii) Have you undergone any mammogram or Pap smear? (If yes, then kindly provide date and the test result)												

F. IF ANSWER TO ANY OF (D) OR (E) QUESTION IS "YES" (EXCEPT D. 1.), PLEASE PROVIDE DETAILS*:

Details of the Treating/ Family Doctor	Nature of ailment/Disease/ Exact Diagnosis etc	First Date of Diagnosis	Details of current symptoms (onset, intensity and duration)	List the current prescriptions or medicines taken for disorder	Is there any further consultation planned
Name: **Address:**					

SECTION III: OTHER INSURANCE INFORMATION*

Please provide details of any Critical illness Insurance cover that you or your family members hold or have applied for Generali Central Insurance Company Ltd. or any other Life or Non-Life Insurance Company

Policy or Proposal No	Company Name	Year of Issue	Medical Conducted for the Policy (Y/ N)	Basic Sum Insured	Decision (Std/ With Extra Premium/ Postpone/ Decline)	Policy Status: In Force/ Lapsed (Mention yr of lapse / Revival Applied For)

SECTION IV: DECLARATION & AUTHORIZATION* and PAYMENT DETAILS:

Payment Details

Premium paid by Cash/ Cheque No		Date:	DD	MM	YYYY
Bank Name		Amount (INR):			
Amount (in words)					
GSTIN (If more than one GSTIN, kindly attach an annexure with details)		PAN (if premium is 1 Lac and above.) -			
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 ₹10000/-					

True to our Go Green initiative, we will send the digitally signed and authenticated policy document to your e-mail address, as you've mentioned in this proposal, and you may download and save a copy of it. If you still wish for a physical copy, you may tick on this box
Yes ☐ No ☐

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 authorised 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 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.
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.
6. 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.
   - 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 ☐ NPO/NGO ☐ Film Actor ☐ Producer ☐ Others.
   If you are an NGO/NPO, please provide Niti Aayog – Darpan Portal registration number_____
   ^Non-profit organization means any entity or organization, constituted for religious or charitable purposes referred to in clause (15) of section 2 of the Income-tax Act, 1961, that is registered as a trust or a society under the Societies Registration Act, 1860 or any similar State legislation or a Company registered under the section 8 of the Companies Act, 2013.
9. I agree that the information/data, contained in this proposal, shall be processed for purposes related to this proposal and the insurance policy that may be issued hereon. I understand that all such information/data will be handled as per the GCICL Privacy Policy, available at https://generalicentralinsurance.com/privacy-policy
10. **ABHA Declaration (Applicable only if you have shared the ABHA number with Us)** - I, hereby declare that I am voluntarily sharing Ayushman 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.
11. 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 abovementioned 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.
12. **Bima – ASBA Declaration** ***(Please tick the box if you want to utilize the Bima-ASBA facility)***
    ☐ I hereby accord my consent to authorise Generali Central Insurance Company Limited to block the applicable premium payable for the aforesaid insurance policy under the BIMA ASBA 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

empaneled third party vendors ☐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 there after 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:	

For Office Use Only	
Intermediary Name:	**Intermediary Code:**
Sales Manager Name:	**Sales Manager Code:**

Declaration By Authorized Representative Or Person With Disability

I, Mr./Ms._____, authorize Mr./Ms. _____ as my authorized representative to act on my behalf, and for all the persons proposed to be insured, in all matters related to this health insurance proposal, including but not limited to:

a) Discussing and obtaining relevant information regarding the health insurance coverage, benefits, features and claims;
b) Providing personal and medical information required for completion and processing of this proposal;
c) Taking decisions regarding my application/proposal, claims, servicing requirement and discharge processes, related to the health insurance policy that GCICL may issue;
d) Coordinate with designated service providers engaged with/by GCICL for administration of the insurance cover; and
e) Signing necessary documents in relation to this health insurance proposal and any other decisions relating to/arising therefrom.

Signature of Proposer: _____

Name of Authorized Representative: _____Relationship with the Proposer: _____

Address: _____Contact No.: _____

Signature of the Authorized Representative _____Date: _____

Name of Witness:_____ Signature of Witness :_____
Date:_____ Place: _____

OR

I, Mr./Ms._____, have been authorized by Mr./Ms. _____, as their representative to act on their behalf in all matters related to this health insurance proposal, including but not limited to:

a) Discussing and obtaining relevant information regarding the health insurance coverage, benefits, features and claims;
b) Providing personal and medical information required for completion and processing of this proposal;
c) Taking decisions regarding my application/proposal, claims, servicing requirement and discharge processes, related to the health insurance policy that GCICL may issue;
d) Coordinate with designated service providers engaged with/by GCICL for administration of the insurance cover; and

e) Signing necessary documents in relation to this health insurance proposal and any other decisions relating to/arising therefrom.

Name of Authorized Representative: _____Relationship with the Proposer: _____

Address: _____Contact No.: _____

Signature of the Authorized Representative: _____Date:_____

Name of Witness:_____Signature of

Witness:_____

Date : _____ Place : _____

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
ISO No: GCH/HP/FCC/PFM/001