GENERALI Central INSURANCE

HEALTH XTRA
PROPOSAL FORM

IO No/Win No.	:
App No	:
Client Code	:
Receipt No	:
Payer ID	:
SB / CA Account No	:
Journal No / Bank Name	:

GUIDELINES FOR FILLING THIS PROPOSAL FORM

1) Insurance is a contract of utmost good faith, requiring the proposer and the insured to disclose all material facts and to avoid suppressing any material facts in response to the questions in the proposal form.
2) Please complete all sections in capital letters and check the boxes where applicable. It is mandatory to furnish all information for fields marked with an asterisk [*].
3) Failure to disclose facts material to the assessment of risk, or providing misleading or partial information, may lead to rejection of the Proposal or cancellation of the insurance policy.
4) This Proposal Form shall serve as the basis of contract for policy issuance and shall be signed by the proposer/authorized person.
5) GCICL is under no obligation to accept any proposal for insurance. Generali Central Insurance Co. Ltd. (GCICL) liability will commence only upon acceptance of this Proposal (subject to the policy terms and conditions) and once the premium is received and realized.

Receipt Date:	**Branch Name:**	**Branch Code:**

I PROPOSER DETAILS

Proposer Name* : ☐ Mr. ☐ Mrs. ☐ Ms. ☐ M/s _____

Date of Birth* : D D M M Y Y Age (in years): _____

Marital Status* : ☐ Married ☐ Single ☐ Widow / Widower ☐ Divorcee ☐ In Live-in relation

Nationality* : ☐ Indian ☐ NRI ☐ Others (please specify _____

Gender* : ☐ Male ☐ Female ☐ Third Gender E-mail ID*:_____

Occupation* ☐ Self Employed ☐ Salaried ☐ Homemaker ☐ Retired

☐ Others (please specify) :_____

PAN : _____ (Mandatory where the premium exceeds Rs. 50,000/- in cash and where premium exceeds Rs. One Lakh in any mode)

Permanent Address: _____

Landmark : _____ City / Town : _____

District : _____ Pin Code* : _____

Telephone No.* : _____ Mobile No.* : _____

Present Address: (If same as above, please tick here) ☐ _____

Landmark : _____ City / Town : _____

District : _____ Pin Code* : _____

Telephone No.* : _____ Mobile No.* : _____

Are you Insured under any existing GCICL Group Health Insurance Policy? * ☐ Yes ☐ No

If Yes, Please Provide the following details with respect to the Proposer
a. Group Health Insurance Policy Number: _____
b. Member ID_____

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

If yes, kindly provide the below details

Product Name: Health Xtra
UIN: GCIHLIP26044V012526

Type of Impairment	:
Percentage of Impairment	:
UDID Number	:

II. DETAILS – Please select the required Sum Insured

Note: Any of the Sum Insured can be opted for, either on Individual basis or on Family Floater basis.

Policy Period * : ☐ 1 Year ☐ 2 Years ☐ 3 Years

Proposed Policy Period* : From : D D M M Y Y To : D D M M Y Y

Cover Type* : ☐ Individual ☐ Family Floater

Family Definition:

Individual/ Non-Floater: *Self, Spouse / Live-in partner, Children, Parents, Parents-In-Law, Siblings, Daughter-in-law, Son-in-law, Grandparents & Grandchildren*
(Up to 10 Lac SI – 4 Adult members + 3 Children, Above 10 Lac SI – 15 members)

Family Floater*: Self, Spouse / Live-in partner, up to 3 Dependent Children (Up to the age of 25 years)*
For Parent's separate floater policy can be taken.

In case, Sum Insured & Optional Covers to be opted on Family Floater basis, please tick on the appropriate Sum Insured & Optional Covers in below table.
In case of Sum Insured & Optional Covers to be opted on Individual basis, please fill table no. III.

Sum Insured	☐ ₹ 5,00,000	☐ ₹ 15,00,000	☐ ₹ 50,00,000
	☐ ₹ 10,00,000	☐ ₹ 20,00,000	☐ ₹ 75,00,000
		☐ ₹ 25,00,000	☐ ₹ 1,00,00,000
		☐ ₹ 30,00,000	
		☐ ₹ 35,00,000	
Pre-Hospitalization Medical Expenses	☐ 60 days ☐ 90 days	☐ 60 days ☐ 90 days	☐ 60 days ☐ 90 days
Post-Hospitalization Medical Expenses	☐ 90 days ☐ 120 days	☐ 120 days ☐ 150 days	☐ 150 days ☐ 180 days

Optional Covers:

Voluntary Deductible	**SI - ₹ 5 Lac**		**SI - ₹ 10 Lac**		**SI - ₹ 15/ 20/ 25 Lac**	
	Deductible	Discount	Deductible	Discount	Deductible	Discount
	☐ ₹10,000	10%	☐ ₹10,000	8%	☐ ₹50,000	15%
	☐ ₹25,000	15%	☐ ₹25,000	15%	☐ ₹75,000	20%
	☐ ₹50,000	25%	☐ ₹50,000	20%	☐ ₹100000	25%
	SI - ₹ 30 Lac		**SI - ₹ 35 Lac**		**SI - ₹ 50/ 75/ 100 Lac**	
	Deductible	Discount	Deductible	Discount	Deductible	Discount
	☐ ₹50,000	10%	☐ ₹50,000	5%	☐ ₹1,00,000	15%
	☐ ₹75,000	15%	☐ ₹75,000	10%	☐ ₹2,50,000	20%
	☐ ₹100000	20%	☐ ₹100000	15%	☐ ₹5,00,000	25%

Cumulative Bonus Booster	☐ Yes ☐ No	
	If yes, please select percentage value	☐ 500% ☐ 1000%
Consumables / Non-Medical Expenses Cover	☐ Yes ☐ No	
Critical Illness Booster	☐ Yes ☐ No	
Mandatory Co-Pay Waiver *(For Insured member aged 61 years and above)*	☐ Yes ☐ No	

Accident Care - The Sum Insured options are available on individual basis only. To opt for the optional cover, please fill the required Sum Insured under Optional Cover in table III. The Sum Insured options can only be selected as available under the specific Sum Insured plan.

Sum Insured	₹ 5L / 10L	₹ 15L/ 20L/ 25L/ 30L/ 35L	₹ 50L / 75L / 100L
Accident Care	₹5,00,000	₹5,00,000	₹5,00,000

(For members aged between 3 to 65 years only)	₹10,00,000	₹10,00,000	₹10,00,000
		₹15,00,000	₹15,00,000
		₹20,00,000	₹20,00,000

III. PROPOSED INSURED DETAILS* (In case the number of persons to be insured is more than 6, please fill the attached Annexure)

Note:
A. For Accident Care, Voluntary Deductible, Pre-Hospitalization and Post-Hospitalization benefit, please fill the required individual cover limits from the options available under the specified Sum Insured Plan as mentioned above and in section II.
B. Opting "PED Coverage for ABCD illness" shall be declared and applicable on individual basis only for both individual and floater cover types.

	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name						
Gender						
Date of Birth (DD/MM/YYYY)						
Marrital Status						
ABHA No^^						
Relationship with Proposer						
Height (Cm)						
Weight (Kg)						
Occupation						
Sum Insured						
Pre-Hospitalization Medical Expenses						
Post-Hospitalization Medical Expenses						
Optional Covers:						
Voluntary Deductible						
Accident Care *(For members aged between 3 to 65 years only)*						
PED Coverage for ABCD Illness *(Asthma, High Blood Pressure, High Cholesterol and Diabetes)*	This benefit can only be selected for the proposed insured member who is suffering from any of the 4 named pre-existing diseases namely, Asthma, High Blood Pressure, deranged Cholesterol and Diabetes.					
	☐ Asthma ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes	☐ Asthma ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes	☐ Asthma ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes	☐ Asthma ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes	☐ Asthma ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes	☐ Asthma ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes
Cumulative Bonus Booster	☐ 500% ☐ 1000%					
Consumables / Non-Medical Expenses Cover	☐ Yes ☐ No					
Critical Illness Booster	☐ Yes ☐ No					
Mandatory Co-Pay Waiver *(For Insured member aged 61 years and above)*	☐ Yes ☐ No					
Please attach age proof document for each insured. The below age proofs will be considered: Passport, PAN Card, Driving License, School/ College leaving certificate, Letter from recognized public authority.						

^^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.

IV. 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 (DOB)				
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 (DOB)				
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				

V. MEDICAL AND HEALTH INFORMATION* (In case the number of persons to be insured is more than 6, please fill the attached Annexure)

Please answer below mentioned questions	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6

1	Do you consume tobacco in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Type- Cigarette/ Beedi/ Cigar/ Gutkha/ Others						
	If you have stopped smoking – Since when	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY
2	Do you consume alcohol in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Type – Beer/ Hard liquor/ Wine/ Others						
3	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity? Yes ☐ No ☐						
	Has any person proposed to be insured been suffering from/suffered in the past/taking treatment for any illness/disease or injury for following medical conditions, presently? YES ☐ NO ☐ (If Yes, please select the disease for the specific proposed insured person)						
	a) Psychiatric/ Mental/ Sleep Disorder	☐	☐	☐	☐	☐	☐
	b) Stroke/ Epilepsy/ Paralysis or other brain / nervous system disorders	☐	☐	☐	☐	☐	☐
	c) Disease related to Ear/ Nose/ Throat	☐	☐	☐	☐	☐	☐
	d) Tuberculosis/Asthma or any lung / respiratory disorder	☐	☐	☐	☐	☐	☐
	e) Hypertension/ Chest pain/ Heart Disease	☐	☐	☐	☐	☐	☐
	f) Liver Disease/ Ulcers (stomach/ duodenum)/ Gall stones/ Hepatitis/ other digestive Disorders	☐	☐	☐	☐	☐	☐
	g) Kidney Failure/ Dialysis/ Kidney Stones/ Prostate/ other kidney disorders	☐	☐	☐	☐	☐	☐
	h) HIV/ AIDS/ Sexually Transmitted Disease	☐	☐	☐	☐	☐	☐
	i) Diabetes/ Thyroid or any other endocrine disorders	☐	☐	☐	☐	☐	☐
	j) Arthritis, Spondylitis, Joint Pain, Slip Disc, Spinal Disorder or any other disorder of muscle/ bone/ joint	☐	☐	☐	☐	☐	☐
	k) Cancer/Tumour- Benign or Malignant	☐	☐	☐	☐	☐	☐
	l) Anaemia or any other blood disorder	☐	☐	☐	☐	☐	☐
	m) Females Specific – Fibroid / Cyst/ Fibroadenoma/ Breast disorder or any other Gynaecological Disorder	☐	☐	☐	☐	☐	☐
	n) Any accidental injury that has caused disability / hospitalization	☐	☐	☐	☐	☐	☐
	o) Treatment for Infertility or has been advised for?	☐	☐	☐	☐	☐	☐
	p) Others (Please Specify with diagnosis)	☐	☐	☐	☐	☐	☐
4	Is any of the female insured pregnant? If yes, please mention the expected date of delivery	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY

VI. ADDITIONAL INFORMATION (In case the number of persons to be insured is more than 6, please fill the attached Annexure)

If any of the proposed insured persons is suffering from/suffered in the past/taking treatment for any illness/disease or injury and the same is declared in Section V.3 above, please provide further details below.

Name of the proposed insured person	Name of Illness/ Surgery	Date of first diagnosis	Medication Details	Is the person fully cured? Yes/No
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		

VII. CONCURRENT/PREVIOUS INSURANCE POLICY DETAILS

Are you having existing Health Policy of Generali Central or are you insured under any other Health Insurance Policy? YES ☐ NO ☐ (If YES, please provide details in below table)

Insured Name	Policy Number	Insurer Name	Policy Period		Sum Insured	Claim Lodged (if Yes, give details)	Product Name
			From	To			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
			DD/MM/YY	DD/MM/YY			
Are you applying for portability / migration?		☐ Yes ☐ No (If yes, portability / migration form to be completed and attached)					

VIII. PREMIUM PAYMENT AND BANK DETAILS*

Instalment Details: If you want to opt for premium payment in instalment option, please tick the required from the below options

Instalment Frequency : Monthly ☐ Quarterly ☐ Half Yearly ☐

E-mandate/E-NACH* ☐ Please provide the Bank Name :

*Link will be sent to 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 auto-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/

Payment Details:

Payment Option : Cheque ☐ Demand Draft ☐ Fund Transfer ☐ Pay Order ☐
Debit Card ☐ Credit Card ☐ Cash ☐

Premium Amount : ₹_____ Amount in Words: _____

Account Holder Name :

Instrument Number : Instrument Date :

Instrument Amount : Bank Name :

GSTIN : (If more than one GSTIN, kindly attach an annexure with details)

Please fill up the request for authorisation 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/-.

IX. ELECTRONIC INSURANCE ACCOUNT DETAILS OF PROPOSER

(Email Id is mandatory)

Do you have an eIA : ☐ Yes ☐ No If No, do you wish to apply for eIA : ☐ Yes ☐ No

If yes, please quote the EIA number : <<_____>>

If applied, please mention your preferred Insurance Repository : <<_____>>

Email Id (Registered with Insurance Repository) : <<_____>>

Your Policy will be credited in your EIA account and your address details as mentioned in the EIA shall override the address provided in this proposal for Insurance. We request you to inform the Repository of any changes in the details immediately.

X. True to GCICL's Go Green initiative, GCICL will send the digitally signed and authenticated policy document to your e-mail address, as you've mentioned in this proposal and, where available/chosen, your eIA, 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 ☐

XI. 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 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 and further understand that no unsolicited information will be sent to me.
   - The information/ data provided by me through this Proposal Form, to GCICL and / or GCICL authorized personnel / agency shall be stored by GCICL, throughout the currency of my relationship with GCICL and used for the purpose 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 / personnel liable for legal 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 and has 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

8) I hereby confirm that the premium payment have been paid by _____, who is having an insurable interest in my policy under this application form. In case of any refund, please process the same in below mentioned proposer's bank account.

9) I am (please tick all that are applicable) ☐ HNI ☐ NRI ☐ Politically Exposed Person ☐ Jeweller ☐ NPO/NGO ☐ Film Actor ☐ Producer ☐ Others
   If you are an NPO/NGO, 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.

10) 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

11) **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

12) 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.

13) **"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 hereby give my/our consent to GCICL to collect, use, process, and share my/our personal information for policy servicing, claim settlement quality, and data analysis purpose, which may be carried out by an empanelled 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 satisfaction (*to download a copy of the Prospectus and for further details about the product, please visit the website at https://generalicentralinsurance.com)*

Date: Place: Proposer Name: _____ Signature / Thumb Impression of Proposer:

XII. A INTERMEDIARY DECLARATION

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. I have further informed the proposer that the details provided herein shall form the basis of the contract of insurance between GCICL and the proposer. I have also 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 to GCICL.

XII. B 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.

I hereby declare that, I have clearly explained the content of this form to the proposer and the proposer has affixed the thumb impression above after fully understanding the content thereof.

Name of Witness : Signature of Witness :

Date: Place: Signature of Agent /POSP/Intermediary:

Name of Agent: Code: POSP PAN:

XII. C 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 :_____

Prohibition of Rebates: Section 41 of the Insurance Act, 1938 (and amendments thereof)

1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 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 prospectus or tables of the insurers.
2) Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to ten lakh rupees.

FOR OFFICE USE ONLY

Intermediary Name :		Intermediary Code :	
Sales Manager Name :		Sales Manager Code :	

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

ANNEXURE – Only applicable if number of persons to be insured is more than 6.

III. PROPOSED INSURED DETAILS* (In case the number of persons to be insured is more than 6, please fill the attached Annexure)

Note:
A. For Accident Care, Voluntary Deductible, Pre-Hospitalization and Post-Hospitalization benefit, please fill the required individual cover limits from the options available under the specified Sum Insured Plan as mentioned above and in section II.
B. Opting "PED Coverage for ABCD illness" shall be declared and applicable on individual basis only for both individual and floater cover types.

	Insured 7	Insured 8	Insured 9	Insured 10	Insured 11	Insured 12
Name						
Gender						
Date of Birth (DD/MM/YYYY)						
Marital Status						
ABHA No^^						
Relationship with Proposer						
Height (Cm)						
Weight (Kg)						
Occupation						
Sum Insured						
Pre-Hospitalization Medical Expenses						
Post-Hospitalization Medical Expenses						
Optional Covers#:						
Voluntary Deductible						
Accident Care *(For members aged between 3 to 65 years only)*						
PED Coverage for ABCD Illness *(Asthma, High Blood Pressure, High Cholesterol and Diabetes)*	This benefit can only be selected for the proposed insured member who is suffering from one or more of the 4 named pre-existing diseases namely, Asthma, High Blood Pressure, deranged Cholesterol and Diabetes.					
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cumulative Bonus Booster	☐ 500% ☐ 1000%					
Consumables / Non-Medical Expenses Cover	☐ Yes ☐ No					
Critical Illness Booster	☐ Yes ☐ No					
Mandatory Co-pay Waiver *(For Insured Member aged 61 years and above)*	☐ Yes ☐ No					

Please attach age proof document for each insured. The below age proofs will be considered:
Passport, PAN Card, Driving License, School/ College leaving certificate, Letter from recognized public authority.

III. PROPOSED INSURED DETAILS* (In case the number of persons to be insured is more than 6, please fill the attached Annexure)

Note:
A. For Accident Care, Voluntary Deductible, Pre-Hospitalization and Post-Hospitalization benefit, please fill the required individual cover limits from the options available under the specified Sum Insured Plan as mentioned above and in section II.
B. Opting "PED Coverage for ABCD illness" shall be declared and applicable on individual basis only for both individual and floater cover types.

	Insured 13	Insured 14	Insured 15
Name			
Gender			
Date of Birth (DD/MM/YYYY)			
Marital Status			
ABHA No^^			
Relationship with Proposer			
Height (Cm)			
Weight (Kg)			
Occupation			
Sum Insured			
Pre-Hospitalization Medical Expenses			
Post-Hospitalization Medical Expenses			
Optional Covers#:			
Voluntary Deductible			
Accident Care *(For members aged between 3 to 65 years only)*			

PED Coverage for ABCD Illness *(Asthma, High Blood Pressure, High Cholesterol and Diabetes)*	This benefit can only be selected for the proposed insured member who is suffering from one or more of the 4 named pre-existing diseases namely, Asthma, High Blood Pressure, deranged Cholesterol and Diabetes.		
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cumulative Bonus Booster	☐ 500% ☐ 1000%		
Consumables / Non-Medical Expenses Cover	☐ Yes ☐ No		
Critical Illness Booster	☐ Yes ☐ No		
Mandatory Co-Pay Waiver *(For Insured member aged 61 years and above)*	☐ Yes ☐ No		
Please attach age proof document for each insured. The below age proofs will be considered: Passport, PAN Card, Driving License, School/ College leaving certificate, Letter from recognized public authority.			

V. MEDICAL AND HEALTH INFORMATION*

Please answer below mentioned questions		Insured 7	Insured 8	Insured 9	Insured 10	Insured 11	Insured 12
1	Do you consume tobacco in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Type- Cigarette/ Beedi/ Cigar/ Gutkha/ Others						
	If you have stopped smoking – Since when	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY	MM/YYYY
2	Do you consume alcohol in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Type – Beer/ Hard liquor/ Wine/ Others						
3	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity? Yes ☐ No ☐						
	Has any person proposed to be insured been suffering from/suffered in the past/taking treatment for any illness/disease or injury for following medical conditions, presently? YES ☐ NO ☐ (If Yes, please select the disease for the specific proposed insured person)						
	a) Psychiatric/ Mental/ Sleep Disorder	☐	☐	☐	☐	☐	☐
	b) Stroke/ Epilepsy/ Paralysis or other brain / nervous system disorders	☐	☐	☐	☐	☐	☐
	c) Disease related to Ear/ Nose/ Throat	☐	☐	☐	☐	☐	☐
	d) Tuberculosis/Asthma or any lung / respiratory disorder	☐	☐	☐	☐	☐	☐
	e) Hypertension/ Chest pain/ Heart Disease	☐	☐	☐	☐	☐	☐
	f) Liver Disease/ Ulcers (stomach/ duodenum)/ Gall stones/ Hepatitis/ other digestive Disorders	☐	☐	☐	☐	☐	☐
	g) Kidney Failure/ Dialysis/ Kidney Stones/ Prostate/ other kidney disorders	☐	☐	☐	☐	☐	☐
	h) HIV/ AIDS/ Sexually Transmitted Disease	☐	☐	☐	☐	☐	☐
	i) Diabetes/ Thyroid or any other endocrine disorders	☐	☐	☐	☐	☐	☐
	j) Arthritis, Spondylitis, Joint Pain, Slip Disc, Spinal Disorder or any other disorder of muscle/ bone/ joint	☐	☐	☐	☐	☐	☐
	k) Cancer/Tumour- Benign or Malignant	☐	☐	☐	☐	☐	☐
	l) Anaemia or any other blood disorder	☐	☐	☐	☐	☐	☐
	m) Females Specific – Fibroid / Cyst/ Fibroadenoma/ Breast disorder or any other Gynaecological Disorder	☐	☐	☐	☐	☐	☐
	n) Any accidental injury that has caused disability / hospitalization	☐	☐	☐	☐	☐	☐
	o) Treatment for Infertility or has been advised for?	☐	☐	☐	☐	☐	☐
	p) Others (Please Specify with diagnosis)	☐	☐	☐	☐	☐	☐
4	Is any of the female insured pregnant? If yes, please mention the expected date of delivery	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY

V. MEDICAL AND HEALTH INFORMATION*				
Please answer below mentioned questions		Insured 13	Insured 14	Insured 15
1	Do you consume tobacco in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Type- Cigarette/ Beedi/ Cigar/ Gutkha/ Others			
	If you have stopped smoking – Since when	MM/YYYY	MM/YYYY	MM/YYYY
2	Do you consume alcohol in any form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Type – Beer/ Hard liquor/ Wine/ Others			
3	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity? Yes ☐ No ☐			
	Has any person proposed to be insured been suffering from/suffered in the past/taking treatment for any illness/disease or injury for following medical conditions, presently? YES ☐ NO ☐ (If Yes, please select the disease for the specific proposed insured person)			
	a) Psychiatric/ Mental/ Sleep Disorder	☐	☐	☐
	b) Stroke/ Epilepsy/ Paralysis or other brain / nervous system disorders	☐	☐	☐
	c) Disease related to Ear/ Nose/ Throat	☐	☐	☐
	d) Tuberculosis/Asthma or any lung / respiratory disorder	☐	☐	☐
	e) Hypertension/ Chest pain/ Heart Disease	☐	☐	☐
	f) Liver Disease/ Ulcers (stomach/ duodenum)/ Gall stones/ Hepatitis/ other digestive Disorders	☐	☐	☐
	g) Kidney Failure/ Dialysis/ Kidney Stones/ Prostate/ other kidney disorders	☐	☐	☐
	h) HIV/ AIDS/ Sexually Transmitted Disease	☐	☐	☐
	i) Diabetes/ Thyroid or any other endocrine disorders	☐	☐	☐
	j) Arthritis, Spondylitis, Joint Pain, Slip Disc, Spinal Disorder or any other disorder of muscle/ bone/ joint	☐	☐	☐
	k) Cancer/Tumour- Benign or Malignant	☐	☐	☐
	l) Anaemia or any other blood disorder	☐	☐	☐
	m) Females Specific – Fibroid / Cyst/ Fibroadenoma/ Breast disorder or any other Gynaecological Disorder	☐	☐	☐
	n) Any accidental injury that has caused disability / hospitalization	☐	☐	☐
	o) Treatment for Infertility or has been advised for?	☐	☐	☐
	p) Others (Please Specify with diagnosis)	☐	☐	☐
4	Is any of the female insured pregnant? If yes, please mention the expected date of delivery	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY	☐ Yes DD/MM/YY

VI. ADDITIONAL INFORMATION				
If any of the proposed insured persons is suffering from/suffered in the past/taking treatment for any illness/disease or injury and the same is declared in Section V.3 above, please provide further details below.				
Name of the proposed insured person	Name of Illness/ Surgery	Date of first diagnosis	Medication Details	Is the person fully cured? Yes/No
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		
		MM/YYYY		

		MM/YYYY		