PROPOSAL FORM
SURAKSHIT LOAN BIMA

***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 the time of acceptance and subsequent to payment of the premium.

Received date: ___ ___ / ___ ___ / ___ ___ ___ ___ Branch code: _____
Branch name: _____

	APPLICANT	CO-APPLICANT
Name	…….. ……..…….. ……..…..... Sur Name First Name Middle Name	…….. ……..…….. ……..…..... Sur Name First Name Middle Name
Relationship		Relationship with Applicant: ……
Nationality		
Father's /Husband Name		
Permanent Address		
Contact Number*	……(Landline) ……(M)*	……(Landline) ……(M)*
Present Address: (If same as above, please tick here) ☐		
Present Address is	☐ Self-Owned ☐ Rented ☐ Co. Leased	☐ Self-Owned ☐ Rented ☐ Co. Leased
Contact Number*	……(Landline) ……(M)*	……(Landline) ……(M)*
Email Id*		
Date of Birth/ Gender	…… Age : ……Yrs M / F	…… Age : ……Yrs M / F
ABHA No^^		
Marital Status	☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced	☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced
No. Of Dependents	……Children ……..Others	……Children ……..Others
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*	
Occupation	☐ Employed ☐ Self Employed (Full time / Part time)	☐ Employed ☐ Self Employed (Full time / Part time)
Education Qualification		
Employer/ Business Name		
Type of Industry		
Designation & Nature of Job		
Monthly Income		
Other Income (If Any)	₹……..……. Source……	₹……..……. Source……
Employer / Business Address		
Employer / Business Contact Number		
Years in Present Occupation		
Loan Account Number		
Loan Amount		
Loan Tenure		
Policy Tenure	☐ 1 Year ☐ 2 Years ☐ 3 Years	
Period of insurance desired	**From:** DD / MM / YYYY **To:** DD / MM / YYYY	
Plan Opted	☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E	
Type of Loan	☐ Home Loan ☐ Personal Loan ☐ Auto Loan ☐ Others (Pls specify):_____	
Sum Insured		
Loss of Job Opted	☐ Yes ☐ No	
Purpose of Loan		
Type of Property		
Property Ownership		
Date of Loan Disbursement	DD / MM / YYYY	
Location of Property		
Financier / Bank		

**(In case where there are more than 2 applicants, Annexure I attached needs to be filled in for each applicant, along with this proposal form)*

^^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

NOMINEE DETAILS FOR APPLICANT*

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				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	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				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	Account Holder Name				

* Nominee for self has to be one of the below mentioned relations.
"Father, Mother, Son, Daughter, Spouse & Others "
If Nominee is "Others" please specify:

NOMINEE DETAILS FOR CO-APPLICANT*

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				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	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				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	Account Holder Name				

* Nominee for self has to be one of the below mentioned relations.
“Father, Mother, Son, Daughter, Spouse & Others “
If Nominee is “Others” please specify:

MEDICAL INFORMATION

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

Sr. No	DETAILS	APPLICANT	CO-APPLICANT
1	Has your Health Insurance / Life Insurance proposal ever been declined?	☐ Yes ☐ No	☐ Yes ☐ No
2	Are you now in good health & entirely free from any mental / physical impairments or deformities (including congenital deformities)?	☐ Yes ☐ No	☐ Yes ☐ No
3	Height / Weight	In CMs: _____ In KGs: _____	In CMs: _____ In KGs: _____
4	Have you lost more than 5 kgs weight in last 3 months?	☐ Yes ☐ No	☐ Yes ☐ No
5	Have you ever suffered from or do you suffer from Diseases of the circulatory system E.g. Heart Disease, Chest pain, High blood pressure, Diseases of Arteries / Veins?	☐ Yes ☐ No	☐ Yes ☐ No
6	Have you ever suffered from or do you suffer from Diabetes Mellitus, Cancer or Tumor of any kind, or any diseases of Blood Glands, Spleen, Ears Eyes, or Skin?	☐ Yes ☐ No	☐ Yes ☐ No
7	Have you ever suffered from or do you suffer from diseases of the Respiratory system (Lung Diseases) e g, Tuberculosis, Asthma. Emphysema, Pneumonia?	☐ Yes ☐ No	☐ Yes ☐ No
8	Do you have / had any complaints of difficulty in Breathing, Blood in Sputum or Persistent Respiratory Infections?	☐ Yes ☐ No	☐ Yes ☐ No
9	Have you ever suffered from or do you suffer from any disease of Genitourinary System / Kidneys?	☐ Yes ☐ No	☐ Yes ☐ No
10	Do you have / had any complaints of swelling over face / Lower limbs?	☐ Yes ☐ No	☐ Yes ☐ No
11	Have you ever suffered from or do you suffer from Diseases of the Nervous system or Mental Disorders e.g. Stroke, Epilepsy, Fits / Fainting attacks, Frequent Headache, Psychiatric Disorders (for e.g. Depression etc.)?	☐ Yes ☐ No	☐ Yes ☐ No
12	Do you have / had any complaints of Weakness in Limbs, tingling numbness, loss of Power in limbs or any other similar complaints?	☐ Yes ☐ No	☐ Yes ☐ No
13	Have you at any time suffered from recurrent episodes of Hepatitis, / Blood in Vomiting or Stool, recurrent Diarrhea?	☐ Yes ☐ No	☐ Yes ☐ No
14	Have you ever had, or been told that you had, or been treated for, or are you intending to seek treatment for HIV, AIDS or AID-related conditions?	☐ Yes ☐ No	☐ Yes ☐ No
15	Have you or any of your immediate family members (Father / Mother / Brother or Sister) have /had Cancer, Heart Attack, and Stroke? Was it prior to 60 yrs of age?	☐ Yes ☐ No	☐ Yes ☐ No
16	Have you ever taken Narcotics / other habit forming Drugs or being treated For the same?	☐ Yes ☐ No	☐ Yes ☐ No
17	Have you been treated for Alcoholism related Diseases?	☐ Yes ☐ No	☐ Yes ☐ No
18	Do you smoke? Or Chew Tobacco If yes, how many cigarettes / beedi’s or grams of tobacco per day? _____	☐ Yes ☐ No	☐ Yes ☐ No

19	Do you consume alcohol? If yes, What type (Spirit, wine, beer etc?) And quantity per week? _____	☐ Yes ☐ No	☐ Yes ☐ No
20	Have you suffered from any other Diseases or Ailments not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No
21	Have you taken treatment / done investigations, for e. g (CT scan, X rays etc) for any ailment?	☐ Yes ☐ No	☐ Yes ☐ No
	If the answer is "Yes" for any of the above please provide details in the space given below.		

2. Have you or the co applicant suffered / are suffering from any disease / illness/ injury? ☐ Yes ☐ No

If yes, indicate in the table below.

Sr. No	Name	Name of Disease/ ailment/ injury Suffering from	First Date of Diagnosis	When First treated	Name of attending medical practitioner with address and telephone no.	Details of current symptoms (onset, intensity and duration)	If fully cured? Answer Yes / No	Is there any further Consultation planned

Do you or co-applicant have other current or pending critical illness Insurance and/or personal accident with Generali Central Insurance Company Limited or from any other Insurance Company? If yes, please give the details as mentioned below:

	Applicant	**Co-Applicant**
Sum Insured		
Type of Policy		
Insured since		
Period of Insurance	DD / MM / YYYY **To** DD / MM / YYYY	DD / MM / YYYY **To** DD / MM / YYYY
Any Exclusions or Special Conditions applied in the policy		
Claims made, if any		

Family Doctor Details

Name: Dr. ……..
Contact Nos. : ……..
Clinic/ Hospital/ Nursing Home No. :
…….

Payment Details

Premium paid by Cash/ Cheque No		Date:	D D	M M	Y Y Y Y
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. ORI 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. 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 GCICL 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 GCICL hereafter. In case of any modification, the applicable information will be provided to GCICL for updating the CKYC Registry Records.

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:	

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 :

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.

ANNEXURE I

LIST OF CO-APPLICANTS PROPOSED FOR INSURANCE

Note: 1. This Annexure will be attached to and forming part of the proposal form and policy to be issued.

Details of Insured:

	CO-APPLICANT 2	CO-APPLICANT 3
Name	…….. …..…….. ……..…..... Sur Name First Name Middle Name	…….. …..…….. ……..…..... Sur Name First Name Middle Name
Relationship	Relationship with Applicant: ……..……	Relationship with Applicant: ……..……
Nationality		
Father's /Husband Name		
Permanent Address		
Contact Number	……(Landline) ……..(M)*	……(Landline) ……..(M)*
Present Address: (If same as above, please tick here) ☐		
Present Address is	☐ Self-Owned ☐ Rented ☐ Co. Leased	☐ Self-Owned ☐ Rented ☐ Co. Leased
Contact Number	……(Landline) ……..(M)*	……(Landline) ……..(M)*
Email Id		
Date of Birth/ Gender	……. Age : ……Yrs M / F	……. Age : ……Yrs M / F
ABHA No^^		
Marital Status	☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced	☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced
No. Of Dependents	……Children ……..Others	……Children ……..Others
PAN		
Note: *PAN number is mandatory where the premium is Rs.50000/- and above in cash and additionally PAN copy is mandatory where premium exceeds one lakh in any mode.*		
Occupation	☐ Employed ☐ Self Employed (Full time / Part time)	☐ Employed ☐ Self Employed (Full time / Part time)
Education Qualification		
Employer/ Business Name		
Type of Industry		
Designation & Nature of Job		
Monthly Income		
Other Income (If Any)	₹……..……. Source……	₹……..……. Source……
Employer / Business Address		
Employer / Business Contact Number		

Years in Present Occupation		
Loan Amount		
Sum Insured		

^^*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*

NOMINEE DETAILS FOR CO-APPLICANT-01*

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				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	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				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	Account Holder Name				

* Nominee for self has to be one of the below mentioned relations.
"Father, Mother, Son, Daughter, Spouse & Others "
If Nominee is "Others" please specify:

NOMINEE DETAILS FOR CO-APPLICANT-02*

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				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	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				
9a.	Account No.				
9b.	IFSC/MICR Code				
9c.	Name of the Bank				
9d.	Account Holder Name				

* Nominee for self has to be one of the below mentioned relations.
"Father, Mother, Son, Daughter, Spouse & Others "
If Nominee is "Others" please specify:

MEDICAL INFORMATION

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

Sr. No	**DETAILS**	**CO-APPLICANT 2**	**CO-APPLICANT 3**
1	Has your Health Insurance / Life Insurance proposal ever been declined?	☐ Yes ☐ No	☐ Yes ☐ No
2	Are you now in good health & entirely free from any mental / physical impairments or deformities (including congenital deformities)?	☐ Yes ☐ No	☐ Yes ☐ No
3	Height / Weight	In CMs: _____ In KGs: _____	In CMs: _____ In KGs: _____
4	Have you lost more than 5 kgs weight in last 3 months?	☐ Yes ☐ No	☐ Yes ☐ No
5	Have you ever suffered from or do you suffer from Diseases of the circulatory system E.g. Heart Disease, Chest pain, High blood pressure, Diseases of Arteries / Veins?	☐ Yes ☐ No	☐ Yes ☐ No
6	Have you ever suffered from or do you suffer from Diabetes Mellitus, Cancer or Tumor of any kind, or any diseases of Blood Glands, Spleen, Ears Eyes, or Skin?	☐ Yes ☐ No	☐ Yes ☐ No
7	Have you ever suffered from or do you suffer from diseases of the Respiratory system (Lung Diseases) e g, Tuberculosis, Asthma. Emphysema, Pneumonia?	☐ Yes ☐ No	☐ Yes ☐ No

8	Do you have / had any complaints of difficulty in Breathing, Blood in Sputum or Persistent Respiratory Infections?	☐ Yes ☐ No	☐ Yes ☐ No
9	Have you ever suffered from or do you suffer from any disease of Genitourinary System / Kidneys?	☐ Yes ☐ No	☐ Yes ☐ No
10	Do you have / had any complaints of swelling over face / Lower limbs?	☐ Yes ☐ No	☐ Yes ☐ No
11	Have you ever suffered from or do you suffer from Diseases of the Nervous system or Mental Disorders e.g. Stroke, Epilepsy, Fits / Fainting attacks, Frequent Headache, Psychiatric Disorders (for e.g. Depression etc.)?	☐ Yes ☐ No	☐ Yes ☐ No
12	Do you have / had any complaints of Weakness in Limbs, tingling numbness, loss of Power in limbs or any other similar complaints?	☐ Yes ☐ No	☐ Yes ☐ No
13	Have you at any time suffered from recurrent episodes of Hepatitis, / Blood in Vomiting or Stool, recurrent Diarrhea?	☐ Yes ☐ No	☐ Yes ☐ No
14	Have you ever had, or been told that you had, or been treated for, or are you intending to seek treatment for HIV, AIDS or AID-related conditions?	☐ Yes ☐ No	☐ Yes ☐ No
15	Have you or any of your immediate family members (Father / Mother / Brother or Sister) have /had Cancer, Heart Attack, and Stroke? Was it prior to 60 yrs of age?	☐ Yes ☐ No	☐ Yes ☐ No
16	Have you ever taken Narcotics / other habit forming Drugs or being treated For the same?	☐ Yes ☐ No	☐ Yes ☐ No
17	Have you been treated for Alcoholism related Diseases?	☐ Yes ☐ No	☐ Yes ☐ No
18	Do you smoke? Or Chew Tobacco If yes, how many cigarettes / beedi's or grams of tobacco per day?	☐ Yes ☐ No	☐ Yes ☐ No
19	Do you consume alcohol? If yes, What type (Spirit, wine, beer etc?) And quantity per week? _____	☐ Yes ☐ No	☐ Yes ☐ No
20	Have you suffered from any other Diseases or Ailments not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No
21	Have you taken treatment / done investigations, for e. g (CT scan, X rays etc) for any ailment?	☐ Yes ☐ No	☐ Yes ☐ No
	If the answer is "Yes" for any of the above please provide details in the space given below.		

2. Have any of the co-applicant(s) suffered / are suffering from any disease / illness? ☐ Yes ☐ No
   If yes, indicate in the table below.

Sr. No	Name	Name of Disease/ ailment/ injury Suffering from	First Date of Diagnosis	When First treated	Name of attending medical practitioner with address and telephone no.	Details of current symptoms (onset, intensity and duration)	If fully cured ? Answer Yes / No	Is there any further Consultation planned

3. Do any of the co-applicant(s) have other current or pending critical illness Insurance and/or personal accident with Generali central insurance company from any other Insurance Company?
   If yes, please give the details as mentioned below:

Applicant	**Co-Applicant 2**	**Co-Applicant 3**
Sum Insured		
Type of Policy		

Insured since		
Period of Insurance	DD /MM / YYYY **To** DD / MM / YYYY	DD /MM / YYYY **To** DD / MM / YYYY
Any Exclusions or Special Conditions applied in the policy		
Claims made, if any		