SURROGACY HEALTH COVER
PROPOSAL FORM

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

IMPORTANT GUIDELINES FOR COMPLETION OF THE FORM

This Policy is specially designed to cover an insured person who is,

(A) A Surrogate Mother- To avail the benefits offered under this product, the product shall only be bought before the implantation of the human embryo in the Surrogate mother's womb.

OR

(B) An Oocyte Donor- To avail the benefits offered under this product, the product shall only be bought before initiation of the Oocyte retrieval procedure.

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
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.

Receive Date	Branch Code	Branch Name

Intermediary Details

Intermediary Name:	
Intermediary Code:	
Intermediary Contact Details:	

I. PROPOSER DETAILS

Proposer Name* : ☐ Mr. ☐ Mrs. ☐ Ms. _____

Gender * : ☐ Male ☐ Female ☐ Others _____

Date of Birth* : | | | | | | | | Age (in years) * :

Profession : ☐ Salaried ☐ Self- Employed ☐ Others : <<Specify details >>

Occupation and Nature of Business / Work : _____

PAN /Form60/61 : _____ (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 : _____

State : _____ Pin Code : _____

Contact Details Phone No.* : _____ Email ID* : _____

Present Address: (If same as above, please tick here) ☐ Landmark : _____ City / Town : _____

State : _____ Pin Code : _____

Contact Details Phone No.* : _____ Email ID* : _____

Are you an existing Generali Central Customer? : ☐ Yes ☐ No

If Yes, Existing Policy No. : Customer ID No. :

Are you Differently Abled, please tick mark on the checkbox to provide confirmation ☐

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

II.	POLICY/PLAN DETAILS*		
Policy Type	:	Individual Basis	
Insured Person	:	☐Surrogate Mother	☐ Oocyte Donor
Sum Insured Applicable		☐2,00,000 ☐3,00,000 ☐5,00,000	☐1,00,000 ☐3,00,000
Policy Term	:	3 years	1 Year
Proposed Policy Period	:	From : D D M M Y Y	To : D D M M Y Y

Please provide supporting documents for Surrogate Mother/Oocyte Donor.

III.	PROPOSED INSURED DETAILS*	
Sr. No.	Name	Insured 1
1	Name of the Insured	
2	Gender	Female
3	Date of Birth (DD/MM/YYYY)	
4	Age	
5	Relationship with Proposer	<<Surrogate Mother>><< Oocyte Donor>>
6	ABHA Number^^	
7	Nationality	Indian
8	Height (cms)	
9	Weight (Kgs)	
10	Occupation	
11	Marital Status	

^^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				
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				

V. MEDICAL AND HEALTH INFORMATION*		
Please answer below mentioned questions		Insured 1
1.	Do you consume tobacco in any form?	☐ Yes ☐ No
	Type- Cigarette/Beedi/Cigar/ Gutkha/Others	
	If you have stopped smoking – Since when	MM/YYYY
2.	Do you consume alcohol in any form?	☐ 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 to be insured is currently suffering from/suffered in the past/taking treatment for any illness/disease or injury for following medical conditions? YES ☐ NO ☐ (If yes, please select the disease for the specific 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)	☐

VI. PREMIUM PAYMENT AND BANK DETAILS*

Payment Frequency : Single

Aadhar E-mandate * : ☐ 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 ☐ Cash ☐ Credit Card

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 authorization form attached with this Proposal Form to receive Claim / Refund Payments, if any, directly into your bank account through NEFT. It is necessary where the premium is more than ₹ 10,000/-.

VII. 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.

VIII. 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 ☐

IX. 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 authorized 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/our 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/We hereby confirm that the premium payment have been paid by _____, who is having an insurable interest in my/our 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 ☐ Jeweler ☐ NPO/NGO ☐ Film Actor ☐ Producer ☐ Others
^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 the Company to use my/our personal information for quality and data analysis purpose which may be carried out by an empaneled third-party vendor ☐ Yes / ☐ No

*Note: I hereby acknowledge that I have read and understood the contents of the prospectus and have been explained the features, contents and terms of the * Prospectus/ Product by the Intermediary/Agent to my/our satisfaction (*to download a copy of the Prospectus and for further details about the product, please visit our website https://generalicentralinsurance.com*

Signature / Thumb Impression of Proposer:

Date: DD/MM/YY Place: Proposer Name: _____

XI. 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.

XI. B VERNACULAR DECLARATION

applicable only when proposer has signed in thumb impression and is witnessed by someone other than agent/ employee of GCICL

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 / Intermediary :

XI. 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 |
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ISO No: GCH/HP/SUR/PFM/001