



PROPOSAL FORM STUDENT SURAKSHA

IO No	
App No	
Client Code	
Receipt No	
Paver ID	

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 cancellation 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.

PERIOD OF INSURANCE*:

D D M M Y Y Y Y

SECTION I: DETAILS OF THE PROPOSER

1. Name of the Proposer (in full) ** Mr. Mrs. Ms.

The proposer's age should be 18 years and above. In case of student below 18 years, parent/ legal guardian will be the 'proposer' mandatorily.

2. Permanent Address and Other Details:

Present address (If same as above, please tick here)

State															Pin code				
Tel No*													Mobile no*						
Email id *																			
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														

3. **Gender*:** Male Female
4. **Marital Status*:** Married Single Divorced Widowed

4. Date of Birth* ____ / ____ / ____
6. Nationality*: _____

SECTION II: DETAILS OF THE INSURED

7. Name of the Insured (in full)* Mr. Mrs. Ms.

8. Address

State	Pin code
Telephone no	Mobile no*
ABHA No^^	
Email id	

^^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>

9. **Gender*:** Male Female
11. **Marital Status*:** Married Single Divorced Widowed
13. **Residential Status:** _____
15. **Passport Number:** _____

10. Date of Birth* ____ / ____ / ____
12. Nationality*: _____
14. Visa Type*: Immigrant Resident Student Travel
16. Educational Qualification: _____



17. 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 _____

18. Contact address in India

State											Pin code		
Telephone no.											Mobile		

SECTION III: DETAILS OF THE COURSE TO BE UNDERTAKEN OVERSEAS

19. Course to pursue*: _____

20. Country to be visited for further studies*: _____

21. University / School Name: _____

22. Course fees: _____

23. Course duration:

24. University address:

State	Pin/ Zip
Country.	
Telephone no.	
E Mail	

SECTION IV: DETAILS OF THE SPONSOR IN INDIA

25. Name: Mr. / Ms _____

Table 1. Summary of the main characteristics of the 1000 samples used in this study.

26. Relationship with the insured: _____

27. Date of birth: ___/___/___

28. Address:

SECTION V: HEALTH

A. Lifestyle Details of Insured: (Please answer by ticking either "yes" or "no" against each of the questions)

Question	Yes	No
Do you suffer or have suffered from any of the following? Diabetes, Hypertension (Blood Pressure), Disease/ Disorders of the Heart, Myocardial Infarction (Heart Attack), Cardiac Bypass Surgery, Coronary Angioplasty, Permanent Pacemaker Implantation, Congenital Birth defects/ diseases, Any disease of brain/ nervous system, Epilepsy/ Fits, Paralysis/ Stroke, Asthma, Chronic Obstructive respiratory disease, Cancer/ Tumour or Lump of any kind, Blood Disorder, Autoimmune disorders, Disorders of Urinary tract and Kidneys, Chronic Kidney Disease, Hepatitis, Chronic Liver Disease/ cirrhosis of Liver, Mental or Psychiatric conditions, Chronic backache or Slipped Disc, Chronic Arthritis, AIDS or HIV Positive, Physical defect or deformity or disability, any other disease or surgery/s performed in the past- Please specify.		

B. Questions to be answered by Female Insureds (Strike off for all Male Insured)

1.	Have you ever suffered /are you suffering from Gynecological problems?	
2.	Are you Pregnant at present? (i) If yes, mention the duration in weeks (ii) Any complications, miscarriage, medical termination of pregnancy or Caesarian?	
3.	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)	

C. If answer to any of V. A to B. question is "Yes", please provide the below mentioned details: (Please attach separate sheets in case the space provided is insufficient)

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 VI: PRODUCT DETAILS*

Coverage (Tick Mark whichever is applicable)	Plan (Tick Mark whichever is applicable)
<input type="checkbox"/> Worldwide	<input type="checkbox"/> Basic USD-50,000 <input type="checkbox"/> Standard USD- 50,000 <input type="checkbox"/> Silver USD- 100,000 <input type="checkbox"/> Silver USD- 150,000 <input type="checkbox"/> Gold USD- 200,000 <input type="checkbox"/> Gold USD- 250,000 <input type="checkbox"/> Platinum USD- 500,000
<input type="checkbox"/> Excluding USA & Canada	<input type="checkbox"/> USD- 25000
<input type="checkbox"/> Asia- Pacific excluding Japan	

11. 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) <input type="checkbox"/>				
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				
10	Account No.				
11	IFSC/MICR Code				
12.	Name of the Bank				
13	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) <input type="checkbox"/>				
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				
10	Account No.				
11	IFSC/MICR Code				
12	Name of the Bank				
13	Account Holder Name				

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.) -			
<i>Please fill up the request for authorization form attached with this proposal form to receive Claim/ Refund payments if any, directly into your bank account through NEFT. It is necessary where the premium is more than ₹10000/-</i>					

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, 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

- 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.
- I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable.
- I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- I declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.
- I, further, declare and warrant that:
 - There is no other material/relevant information, that has not been disclosed to GCICL and if any information given in this proposal is found to be untrue, the insurance policy shall be void ab initio and the premium shall be forfeited to GCICL.
 - 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.
- 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 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.

9. **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.

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. I consent to the fact that GCI may download my/proposer's KYC 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 KYC 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 KYC 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 :
	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:

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

- Discussing and obtaining relevant information regarding the health insurance coverage, benefits, features and claims;
- Providing personal and medical information required for completion and processing of this proposal;
- Taking decisions regarding my application/proposal, claims, servicing requirement and discharge processes, related to the health insurance policy that GCICL may issue;
- Coordinate with designated service providers engaged with/by GCICL for administration of the insurance cover; and
- 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: gcticare@generalicentral.com |

Toll-free Phone: 1800 220 233 / 1860 500 3333/ 022 6783 7800

ISO : GCH/HP/FSU/PFM/001