

10. Family doctor details: Dr.												
Address												
State						Pin code						
Telephone no.						Fax no.						
Email id												

11. Are you an existing Future Generali customer*? Yes / No. If yes, please provide:

Existing policy no: _____ Customer id no: _____

12. Plan details*: (please refer to the brochure for details of the plan before choosing the plan)

Options: Individual (in case sum insured opted on individual basis kindly fill details in table number 19 below)

Floater (in case sum insured opted on floater basis kindly tick the required plan below)

Plans			
Vital	₹ 300,000	₹ 500,000	₹ 1,000,000
Superior	₹ 1,500,000	₹ 2,000,000	₹ 2,500,000
Premiere	₹ 5,000,000		₹ 10000000

13. Voluntary deductible:

Deductible amount in ₹ Per claim (please tick any one deductible as per the plan opted)

Discount in % in lieu of voluntary deductible

Options		A	B	C
Vital plan	Deductible	<input type="checkbox"/> ₹ 10,000	<input type="checkbox"/> ₹ 25,000	<input type="checkbox"/> ₹ 50,000
	Discount	10.00%	15%	20.00%
Superior plan	Deductible	<input type="checkbox"/> ₹ 50,000	<input type="checkbox"/> ₹ 75,000	<input type="checkbox"/> ₹ 1,00,000
	Discount	15.00%	20.00%	25.00%
Premiere plan	Deductible	<input type="checkbox"/> ₹ 1,00,000	<input type="checkbox"/> ₹ 2,50,000	<input type="checkbox"/> ₹ 5,00,000
	Discount	15.00%	20.00%	25.00%

14. Policy term *(please tick the term opted): 1 year 2 years 3 years

In case policy term more than one year, installment option is available. Please tick any one option in case you want to opt for:

Monthly Quarterly Half yearly

Please Note: Under installment option, for policies issued from 1st to 15th of the month, 5th of month shall be the Automated Clearing House (ACH) debit date. For policies issued from 16th to 31st of the month, 25th of the month shall be the ACH debit date.

15. Family definition:

- **Vital plan:** - Family means - self, spouse, dependent children (unmarried and up to the age of 25 years) and dependent parents
- **Superior plan & Premiere plan:** Family means-self, spouse, dependent (unmarried and up to the age of 25 yrs) or non – dependent children, dependent or non – dependent parents, dependent siblings, daughter in law, son in law, parents in law, grandparents and grandchildren

Note - any of the above plans can be opted either on individual basis or on floater basis.

*For Individual and Family Floater cover kindly indicate details of all the members to be covered as per the table below.

*Please note for Family Floater cover do not fill anything in sum insured & premium computation column since sum insured and Voluntary deductible option (if opted) is common for all members.

16. Details of persons to be insured* (in case the nominee is a minor, please provide the name of the appointee)**

Sr. No	Name	Gender	Date of birth	Relationship with proposer	Height	Weight	Occupation	Nominee name**	Relationship of nominee with insured	Plan & sum insured/ Voluntary Deductible opted	Premium computation individual or floater (for office use only)
1	Primary insured			Self							
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

17. Section applicable for females only:

a. Please confirm if any of the persons to be insured is pregnant - Yes / No

b. Please indicate obstetric details in below table for all females insured:

Sr. No	Insured name	Number of living children as on date	Any maternity related complications in present or past , For example miscarriage, gestational diabetes, ectopic pregnancy or any other, please provide details

18. Health questions*: please answer „Yes“ or „No“. If „Yes,“ please provide details below.

Sr no	A	B	C	D	E	F	G
	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity?	Do you regularly consume tobacco / alcohol or smoke - (please specify - yes/no. If yes please mention - quantity / day, number of years since consuming/ smoking)	Does any person to be insured suffer or has suffered in the past from any of the following? Disorder of the heart including ischemic heart disease / rheumatic heart disease, or circulatory system, chest pain, high blood pressure, stroke, asthma, any respiratory condition, cancer or tumour / lump of any kind, diabetes, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychiatric conditions, any disease of brain or nervous system, fits (epilepsy), slipped disc, backache, any congenital / birth defects / disease, AIDS or tested positive for HIV, or any other disease - yes / no. If „yes“, indicate in the table given below.	Name of disease / illness / injury suffering from, in the past or at present. Any other diseases or ailments not mentioned? If „yes“, give details in the table given below.	Disease / illness / injury / suffering since when / when first treated (applicable to question 21-c and d both). If applicable please mention details. If not applicable please mention „no“ in the table given below	Treatment / Medication received / receiving. If applicable please mention details. If not applicable please mention „no“ in the table given below	Are you fully cured? (Yes /No) - applicable only if any of the points „c“ to „f“ is „Yes“
Insured 1	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 2	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 3	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 4	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 5	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 6	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 7	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 8	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 9	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 10	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 11	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 12	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 13	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 14	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 15	Yes/no	Yes/no	Yes/no	Yes/no			

19. Other concurrent health insurance information* (please provide details of any health insurance cover that you or your family members hold for Future Generali Insurance Company Limited Or any other health insurance)

Description	Policy no	Name & address of insurance company	Sum insured	Period of insurance (first inception date -dd/mm/yy)	From: dd/mm/yy to: dd/mm/yy	Claim details, claim amount received or receivable (in Rs)
Insured 1						
Insured 2						
Insured 3						
Insured 4						
Insured 5						
Insured 6						
Insured 7						
Insured 8						
Insured 9						
Insured 10						
Insured 11						
Insured 12						
Insured 13						
Insured 14						
Insured 15						

20. In case of portability/ migration, kindly fill portability/ migration request form along with this form.

21. Attach age proof document for each insured. Please tick whichever is applicable: Passport PAN Card

- Driving license School/college leaving certificate Letter from recognized public authority
 Others, please specify.

22. Payment Details

Premium paid by Cash/ Cheque No	Date:	DD	MM	YYYY
Bank Name	Amount (INR):			
Amount (in words)				
GSTIN (if more than one GSTIN, kindly attach an annexure with details)	PAN (if premium is 1 Lac and above.) -			
Please fill up the request for authorization form attached with this proposal form to receive Claim/ Refund payments if any, directly into your bank account through NEFT. It is necessary where the premium is more than ₹10000/-				

23. 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 FGIICL 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 FGIICL.
 - Service related information from FGIICL, 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 FGIICL and/ or FGIICL authorised person/ agency, shall be stored by FGIICL, throughout the currency of my relationship with FGIICL, and used for the purposes relating to my proposal for insurance cover and/or servicing policies issued in my favour, whether by FGIICL or its authorized partners. I also understand that the said storage is necessary for my consumption of the services and consent to not hold FGIICL 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 FGIICL 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.
- I am (please tick all that are applicable) HNI NRI Politically Exposed Person Jeweller NGO Film Actor Producer Others.

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://general.futuregenerali.in/>)

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 FGIICL 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 FGIICL, be treated as null and void and the premium amount against the policy may be forfeited by FGIICL.

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:
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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.



ISO No. FGH/UW/RET/84/11

Future Generali India Insurance Company Limited. IRDAI Regn. No. 132 | CIN: U66030MH2006PLC165287.
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UIN: FGIHLIP22189V032122

Health Total