FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

PROPOSAL FORM
FUTURE HEALTH SURAKSHA

IO No.	
App No	
Client Code	
Receipt No	
Payer ID	
SB/CA Acc No	
Journal no/ Bank name	

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.*

DESIRED PERIOD OF INSURANCE*: D D M M Y Y Y Y D D M M Y Y Y Y

1. PROPOSER DETAILS

Name of the Proposer*	..... Sur Name	..... First Name	..... Middle Name
Full Permanent Address*			
State		Pin code*	
Present Address: (If same as above, please tick here) ☐			
State		Pin code*	
Contact Number*	Landline:	Mobile*:	
Email Id*			
Date of Birth*	D D / M M / Y Y Y Y	Gender*	☐ Male ☐Female ☐Third Gender
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*		
Marital Status*	☐Married ☐Single ☐ Widow/Widower ☐ Divorced ☐ Live-in Relationship		
Nationality*			
Occupation	☐ Service ☐ Self Employed ☐Others: _____		
Are you an existing Future Generali Customer*? If yes, please provide: Existing Policy No.:_____Customer ID No.: _____			☐ Yes ☐No

Note: Pin code is mandatory. The premiums for respective Zones will be based on Proposer's residence

2. FAMILY DOCTOR DETAILS*

Name of the Dr*	..... Sur Name	..... First Name	..... Middle Name
Full Address*			
State		Pin code	

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Contact Number	Landline:	Mobile:
Email Id		

3. DETAILS OF INSURED*

Note: Proposer can propose cover only for self, spouse, child/children and dependent parents.

DEFINITION:-

 # For Individual Plan: - Family means – Self, Spouse/Live-in partner, Your 4 dependent Children (unmarried and up to the age of 25 years) and dependent Parents.

 # For Family Floater Plan: - Family means – Self, Spouse/Live-in partner, Your 3 dependent Children (unmarried and up to the age of 25 years).

Note: - # For Individual plan, kindly indicate all the Plan and Sum Insured details of all the members to be covered

 # For Family Floater plan, the Plan option and Sum Insured will float over the family members covered under the policy. Please do not fill anything in Premium Computation Column.

Details		Self	Spouse/ Live-in partner	First Child	Second Child	Third Child	Fourth Child	First Dependent Parent	Second Dependent Parent
Name									
Gender									
Date of Birth/ Age									
ABHA No^^									
Relationship with proposer									
Height									
Weight									
Occupation									
Plan/ Sum Insured options# (Individual)	Gold Plan	☐100000** ☐150000** ☐200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐ 450000 ☐500000	☐100000** ☐150000** ☐200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐ 450000 ☐500000	☐50000** ☐100000** ☐ 150000** ☐ 200000 ☐ 250000 ☐300000 ☐ 350000 ☐ 400000 ☐450000 ☐ 500000	☐50000** ☐100000** ☐150000** ☐ 200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐ 450000 ☐ 500000	☐ 50000** ☐100000** ☐150000** ☐ 200000 ☐250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐450000 ☐500000	☐50000** ☐100000** ☐150000** ☐200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐400000 ☐ 450000 ☐ 500000	☐ 100000** ☐ 150000** ☐ 200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐ 400000 ☐ 450000 ☐ 500000	☐ 100000** ☐ 150000** ☐ 200000 ☐ 250000 ☐ 300000 ☐ 350000 ☐400000 ☐450000 ☐ 500000
	Topaz Plan	☐100000** ☐ 200000 ☐300000 ☐ 400000 ☐ 500000	☐100000** ☐200000 ☐ 300000 ☐400000 ☐ 500000	☐ 100000** ☐200000 ☐ 300000 ☐ 400000 ☐500000	☐ 100000** ☐ 200000 ☐ 300000 ☐400000 ☐ 500000	☐100000** ☐200000 ☐ 300000 ☐400000 ☐500000	☐ 100000** ☐ 200000 ☐ 300000 ☐ 400000 ☐500000	☐100000** ☐200000 ☐300000 ☐400000 ☐500000	☐100000** ☐200000 ☐300000 ☐400000 ☐500000
	Platinum Plan	☐600000 ☐750000 ☐800000 ☐900000	☐600000 ☐750000 ☐800000 ☐900000	☐600000 ☐750000 ☐800000 ☐900000	☐600000 ☐750000 ☐800000 ☐900000	☐600000 ☐750000 ☐800000 ☐900000	☐600000 ☐750000 ☐800000 ☐900000	☐600000 ☐750000 ☐800000 ☐900000	☐600000 ☐750000 ☐800000 ☐900000

		☐1000000	☐1000000	☐1000000	☐1000000	☐1000000	☐1000000	☐1000000	☐1000000
	Ruby Plan	☐600000 ☐750000 ☐1000000	☐600000 ☐750000 ☐1000000	☐600000 ☐750000 ☐1000000	☐600000 ☐750000 ☐1000000	☐600000 ☐750000 ☐1000000	☐600000 ☐750000 ☐1000000	☐600000 ☐750000 ☐1000000	☐600000 ☐750000 ☐1000000
Plan/ Sum Insured option[#] (Family Floater)	Gold Plan	☐200000 ☐250000 ☐300000 ☐350000 ☐400000 ☐450000 ☐500000							
	Topaz Plan	☐200000 ☐300000 ☐400000 ☐500000							
	Platinum Plan	☐600000 ☐750000 ☐800000 ☐900000 ☐1000000							
	Ruby Plan	☐600000 ☐750000 ☐1000000							
Premium computation[##]									
Premium (including GST)									

Note: Sum insured of ₹ 50000, 100000, 150000 for all Zones is available only for Children up to age of 25 years.

[##] Premium for floater will be as per the age of the eldest member)

^^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

4. 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				

5. Policy term* (please tick the term opted): ☐1 Year ☐2 Years ☐3 Years.

Instalment option is available for all the policy terms. Please tick any one option in case you want to opt for:

☐ Monthly ☐ Quarterly ☐Half Yearly

Note: Duly filled and signed ACH/ECS/E-Mandate form shall be submitted for instalment option.

Please tick in case you opt for single premium payment, with long term discount for 2 years / 3 years policy period: ☐

6. Health Questions* (Please answer "Y" for Yes or "N" for No against each of the questions.)

Sr. no	Description	Insured	Spouse/ Live-in	First Child	Second Child	Third Child	Fourth Child	First Dependent	Second Depend

			partner					Parent	ent Parent
A	Are / were you a regular smoker? (Yes/No)								
B	Does any person to be insured suffer or has suffered from any of the following? Disorder of the heart, or circulatory system, chest pain high blood pressure, stroke, asthma, any respiratory condition, cancer or tumor 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, if yes please mention details								
C	Name of disease/ illness/ injury suffering from, in the past or at present								
D	Disease/ illness/ injury suffering since when/ when first treated (applicable to question b and c, both)								
E	Treatment/ medication received/receiving								
F	Are you fully cured? (Yes/No)								

Please confirm if any of the persons to be insured is pregnant (For females only) _____

7. A) Do you want to get a Loyalty Discount*: ☐Yes / ☐No

A loyalty discount will be applicable if the insured already has a separate Retail health insurance policy (other than Future Health Suraksha/ Personal Accident/ Travel) from Future Generali India Insurance Co. Ltd. The loyalty discount shall continue only if the insured maintains the separate health insurance policy with us. Please provide the complete details in the below table along with the policy copy to avail the discount. In case the policy copy is not submitted, discount shall not be allowed.

B) DETAILS OF OTHER CONCURRENT HEALTH INSURANCE POLICIES*:

Insured Person	Do you have any other Health Insurance policy with Future Generali India Insurance or any other insurance company?	Policy No	Name of the insurer	Policy sum insured	Period of Insurance	Claims Received/ Receivable (in ₹)
Insured	☐ Yes ☐ No					
Spouse/ Live-in partner	☐ Yes ☐ No					

First Child	☐ Yes ☐ No					
Second Child	☐ Yes ☐ No					
Third Child	☐ Yes ☐ No					
Fourth Child	☐ Yes ☐ No					
First Dependent Parent	☐ Yes ☐ No					
Second Dependent Parent	☐ Yes ☐ No					

Note: -1) In case of Portability/ Migration, kindly fill Portability/ Migration Request Form along with this form.

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/-					

8. 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 ☐

9. 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 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.

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 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.
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 FGIICL Privacy Policy, available at https://general.futuregenerali.in/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 Future Generali India 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 FGII 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 FGII hereafter. In case of any modification, the applicable information will be provided to FGII 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://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.

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TOTAL INSURANCE SOLUTIONS

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

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 FGIICL may issue;
d) Coordinate with designated service providers engaged with/by FGIICL 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 FGIICL may issue;
d) Coordinate with designated service providers engaged with/by FGIICL 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:**
POSP Name	**POSP Code**
POS PAN No.	
Date and 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.

ISO No. FGH/UW/RET/202/11

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

Regd. and Corp. Office: 801 and 802, 8th floor, Tower C, Embassy 247 Park, L.B.S. Marg, Vikhroli (W), Mumbai – 400083. Call us at: 1800-220-233 / 1860-500-3333 / 022-67837800 | Fax No: 022 4097 6900 | Website: https://general.futuregenerali.in | Email: fgcare@futuregenerali.in. Trade Logo displayed above belongs to M/S Assicurazioni Generali - Societa Per Azioni and used by Future Generali India Insurance Co Ltd. under license.