IFFCO-TOKIO

IFFCO-TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office: 34, Nehru Place, New Delhi - 110 019

PROPOSAL FORM FOR INDIVIDUAL MEDISHIELD POLICY

1. **Details of the Proposer**
   a. Name : Mr./Ms
   b. Address:

   c.Telephone/Mobile
   d.E-mail
   e.Nationality f. Annual Income :
   g.Profession : Salaried ☐ Self Employed ☐ Others ☐ Details _____

   h.ID Proof Type: PAN ☐ Passport ☐ Driving Licence ☐ Voter's Card ☐ Others ☐
   i. ID No.

2. Name and address of the Family Doctor
   a. Telephone
   b. Qualification

3. Sum Insured Opted : Rs. _____/-
   A. On Each Insured Person Basis ☐ or B. On Family Basis ☐

4. Critical Illness Opted : Yes ☐ No. ☐

5. Proposed Policy Period: From **Date _____** **to** **_____Date**

6. Details of the persons to be insured

S.No	Name of Insured Person	Height	Weight	Date of Birth	Gender	Occupation	Relationship with the Insured
a)							
b)							
c)							
d)							
e)							
f)							

7. NOMINEE DETAILS

In the event of the death of an insured person any payment due under the policy shall become payable to the nominee in accordance with the policy terms and conditions. The nominee must be an immediate relative of the proposer. For all other persons proposed to be insured, the proposer shall be the nominee.

Nominee Name **Relationship** **Address of the Nominee**

_____ _____ _____

8. **Previous/Existing Insurance Particulars**

a. Details of present/previous medical insurance like Individual, Family or Group Health Policy, Cancer Policy, Critical Illness or any other Policy for all the Insured Person

Note: A photocopy of the expiring Policy or current Renewal Notice is necessary for transfer of continuity of benefits, if applicable.

Name of Insured Person	Policy No.	Name and address of Insurance Co.	Sum Insured	Period of Insurance

b. Details of claims lodged under such Policies during the last 3 years or earlier

S.No.	Name of Insured Person	Date of claim	Nature of claim	Amount of claim

c. Have you been denied Health Insurance Cover or your Health Insurance Cover been cancelled by any of the Insurance Company?

d. If yes, please specify the Reasons for denial or cancellation of your Health Insurance cover ?

9. Is any of the persons proposed for insurance receiving any treatment/ medication or has in past received treatment for any medical condition or disability ?
If yes, indicate details in the Table given below

S.No.	Name of Insured Person	a)Name of disease/injury suffering from b)Treatment/medication received /receiving	Date first treated	Whether fully cured ?

10.Have any of the persons proposed for insurance ever suffered from any of the diseases / illness particularly cancer , renal failure ,coronary artery disease, Paralytic stroke , Major organ transplant, Accident which has lead to loss of limbs, End stage liver disease ,Major burns, Coma ,Multiple Sclerosis.

Yes ☐ No ☐

If yes , Pls. provide all relevant details :

S.No.	Name of Insured Person	a)Name of disease/injury suffering from b)Treatment/medication received /receiving	Date first treated	Whether fully cured ?

11. Any additional facts which affect the proposed insurance and should be disclosed to the insurer. (if required , please attach additional sheet duly signed)

_____

Note: If answer to the question 8b/ 9/10 is "Yes or if you are above 45 years of age please submit the Medical certificate in the prescribed format duly completed and signed by a Consulting Physician/ Surgeon along with the following test reports :ECG , Blood Sugar (PP, fasting and Urine), Liver Function Test and Kidney Function Test. We may also request you to submit additional Medical report as applicable

1. I/We 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 knowledgeand that I/We am/are authorized to propose on behalf of these persons.
2. I understand that all information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the Policy will come into force after full receipt of the premium chargeable.
3. I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the life to insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to the insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seekiung information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Government and/or Regulatory authority.

Date

Signature of proposer

Name of proposer

Vernacular Declaration:
Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent/employee of the Company

Name of the Proposer :_____

The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same :

Signature of the Proposer :
Date :

Signature of the Witnesss
Name of the Witness :

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PAYMENT DETAILS
Instrument Type : Cash ☐ Cheque ☐ Debit Card ☐ Credit Card ☐ Others _____

Instrument No.	Name of the Premium Payor	Bank Details	Date	Amount (in Rs.)

Crossed Cheque/DD/Pay Order must be made in favour of 'Iffco Tokio General Insurance Co. Ltd.' only.

SECTION 41 OF THE INSURANCE ACT 1938

PROHIBITION OF REBATES

Payment of rebates is expressly prohibited under Section 41 of the Insurance Act, 1938.

1. 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 or risk relating to lives or property in India any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy nor shall any person taking out or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the Insurer.

2. Any person making default in complying with the provisions of this Section shall be punishable with fine, which may extend to Rs.500/-.

Agent's declaration

I, _____-(Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.
License No. (Advisor/Corporate Agent/Broker/Relationship Officer)/Agency Code/Broker Code :

Date : Place : Signature of Agent

For Office Use Only

Checklist for Underwriter :

1. Medical Reports (if applicable)
2. Approving Authority : SBU/ Regional Office/ Corporate Office
3. Approval /E-mail Approval attached :

SBU/LSC/BIMA KENDRA CODE :

Name of the Underwriter : Signature of the Underwriter

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TO BE COMPLETED BY CONSULTING PHYSICIAN# /SURGEON

(Applicable for those with adverse medical history* and / or above 45 years of age)

01 Name Of The Insured Person :

02 History:

A) Present Complaints And Investigation, If Any :

B) Any Past History Of Diseases :

Operations, Accidents, Investigations

With Date, Major Medical Complaints

Or Hospitalisation

C) Details Of Present And Past :

Medication With Duration

D) Is He/She Cured Of Diseases, If Any? :

When Was The Treatment, If Any,

Given, Stopped?

03 General Examination :

04 Systematic Examination :

*** reply to the questions 8 being "No" and reply to question 9, 10 and /or 11 being "Yes"**

Signature Of Proposer

Date :

Place:

Signature Of Consulting Physician #

Name Of Consulting Physician

Qualifications#:

Address:

Tel. No.

 # Minimum qualification of Physician should be MBBS

To be completed by Official of Insurance Company

Do you consider the risk as acceptable? :

Competent Authority to accept the Proposal :

Name :

Signature :