



IFFCO-TOKIO GENERAL INSURANCE CO. LTD
 Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

COMPREHENSIVE ACCIDENTAL HOSPITALISATION INSURANCE (UIN: IFFHLIP21354V032021)

PROPOSAL FORM (URN: IAH/IFFHLIP21354V032021/PF-01)

PROPOSER DETAILS

Name					
Address					
City		State		Pin Code	
Email Address		Mobile No.			
Policy documents will be sent to the above email-ID			Do you still need the physical Copy? Yes <input type="checkbox"/> No <input type="checkbox"/>		
KYC Details (Please attach self-attested photo copies)					
<input type="checkbox"/> PAN No.	<input type="checkbox"/> AADHAR No.	<input type="checkbox"/> Any other (Please Specify) _____			
KYC Document Number					

Do you or any of your family members work in any hazardous industry that involve working at heights, underground, with electricity, hazardous substances / chemicals or on offshore locations? (If Yes, please fill annexure 1) Yes No

Do you or any of your family members engage in any competitive or professional sports or any hazardous avocations like:

Racing on wheels Horseback racing Big game hunting Sea diving

Any othersplease provide full details

DETAILS OF THE PERSONS TO BE INSURED

Do you wish to buy a cover for:

Yourself alone Self +Spouse Self + Spouse + Dependent Children (upto 2 children only)

In case of (ii) or (iii) above, please full submit particulars of dependent family members proposed to be insured below.

Name	Date of Birth	Gender	Relation	Occupation	Annual Income
			Self		

SUM INSURED AND PLAN

Sum Insured chosen Rs Plan

Period of Insurance From..... To.....

Is there any health problems/ disabilities suffered by yourself or by any dependent sought to be insured? (If Yes, please fill annexure 2) : Yes No

If you have any other Medical or Accident Insurance Cover, give name of each Insurance Company and Amount of Insurance.....
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Have you ever claimed / received compensation under any Accident Insurance Policy in the past? (If Yes, please fill annexure 3) Yes No

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 anytime 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 declare that persons proposed include only my dependent family members. I have given complete information relating to instances of pre-existing diseases and disabilities for myself and all my family members. I understand that the above stated pre-existing diseases and any other pre-existing medical conditions will not be covered under this policy.
7. I declare that the above answers are true to the best of my knowledge and belief, that I have disclosed all particulars affecting assessment of the risk. I understand that the Insurer may wish to seek additional information from hospital/s and doctor/s concerned / any other person including insurance companies and I consent for the same.
8. I agree that this proposal and declaration shall be the basis of the contract between me and this Company.

Place:

Proposer's Signature:

Date:

ASSIGNMENT:

I,.....DO HEREBY ASSIGN THE MONIES PAYABLE BY THE IFFCO-TOKIO General Insurance Co.Ltd., in the event of my death due to accident to Shri / Smt / Kum (Name & Relationship to the Insured) and I further declare that his/her/their receipt shall be sufficient discharge to the Company.

Date :

Signature of the Policy holder:

Signature of the Witness:

Name & Address of the Witness:

PROHIBITION OF REBATES

The following is the copy of 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 commission payable or any rebate or the premium shown on the policy nor shall any person taking out or renewing continuing a policy except any rebate as may be allowed in accordance with the published prospectuses 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 Ten Lakh rupees.

ANNEXURE 1:

If you or any of your family members work in any hazardous industry that involve working at heights, underground, with electricity, hazardous substances / chemicals or on offshore locations, please provide details below

- Profession, Occupation, Trade or Business:(Please describe clearly with nature of duties)
- Are you primarily engaged in administrative function or a desk bound job?
- Does your occupation require you to engage in manual labour and use special protective gear?

ANNEXURE 2:

Please provide the detail of any health problems/ disabilities suffered by yourself or by any dependent sought to insured. If the answer to any of (a) to (e) is "Yes" then please provide the name of the family member affected

Sr No	Question	Yes	No
	Have you or any covered family member ever suffered from or have been advised that you have any of the following conditions and/or are taking treatments for any of these conditions?		
a	Fits / Epilepsy / Stroke / Paralysis?		
b	Cerebral palsy/ Polio / Myopathy?		
c	Vertigo / Blackouts?		
d	Physical defect and deformity leading to gait instability		
e	Sleep disorder /Mental/ Psychiatric Illness.		

In case any member is suffering from any other disability or disease, kindly give full details

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ANNEXURE 3:

Have you ever claimed / received compensation under any Accident Insurance Policy in the past? If so, give full particulars here below:

Name of the Claimant	Circumstances of Loss	Date of accident	Amount of Claim	Type of Injury	Name of Insurer