IFFCO-TOKIO
Muskurate Raho

Insured Declaration Form for Internal Health Product Conversion/Change in Sum Insured in existing IHP/FHP

1. I want to opt product change:

I, undersigned_____holding Iffco -Tokio's Individual Medishield (IMI)/SwasthyaKavach(SKP)policy/Health Protector Policy(IHP)/family Health Protector Policy(FHP),having Policy number _____ , expiring on _____.

I, hereby declare that I would like to convert my existing ITGI health insurance policy, as per below:

1	IMI to IHP (Individual Medishield to Individual Health Protector)	
2	IMI to FHP (Individual Medishield to Family health Protector)	
3	SKP to FHP (Swasthya Kavach To family health Protector)	
4	SKP to IHP (Swasthya kavach To Individual Health Protector)	
5	IHP to FHP (Individual Health Protector to Family Health Protector)	
6	FHP to IHP (Family Health Protector to Individual Health Protector)	
7	Along with above selection **OR** I like to opt **Room Rent Waiver (RRW)** option. (On additional payment of 6 % of basic premium)	

2.I want to opt following add on cover/change under my IHP / FHP Policy No: _____

1	Critical illness cover (On additional payment of 30% of Basic Premium)	

Annexure (A & B) must be filled ONLY in case of Critical Illness coverage OR Sum Insured enhancement requested with past claim/s experience/ Declared PED: Pre existing disease

Name of insured Person covered in expiring policy is as per below:

Sr.No.	Name of Insured Person	Existing Sum Insured	New Sum Insured
1			
2			
3			
4			
5			

Insured Declaration:

This duly signed & filled declaration form would be the part of main proposal form, which was filled and signed by me/us at the time of taking insurance from IFFCO TOKIO, first time.

The policy coverage, Rates, terms & Conditions have been explained and have been understood by me and I have agree to pay the applicable premium with respect to the option selected by me as above.

IFFCO-TOKIO GENERAL INSURANCE
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Annexure: A

Sr. No.	Have any of the persons proposed to be insured ever suffered from?are currently suffering from any of the following:	Insured Person				
		1	2	3	4	5
1	High or low blood pressure					
2	Diabetes					
3	Chest pain Ischemic heart disease or any other Heart disorder Valve Related Disorder					
4	Arthritis Spondylosis or any other disorder of the muscle/bone/joint like ligament/meniscus tear etc					
5	DUB Fibroid Cyst/Fibroadenoma or any other Gynaecological/Breat disorder					
6	Asthma/COPD or any other lung/Breathing disorder					
7	Tuberculosis					
8	Ulcer (stomach/duodenal) hepatitis cirrhosis or any other Digestive or Liver/Gallbladder Disorder					
9	Renal failure Kidney/ureteric stone or any other Kidney/Urinary tract or Prostate disorder					
10	Dizziness Stroke Epilepsy(fits) Paralysis or other brain/ nervous system disorder/ Multiple Sclerosis					
11	Thyroid diorder or any other endocrine disorder					
12	Tumor-benign or malignant any ulcer/growth/cyst/mass or cancer					
13	Diseases of the Nose/Ear/Throat/Teeth/Eye (please mention Diopters for refractive errors)					
14	HIV/AIDS or sexually transmitted diseases or any immune system disorder					
15	Anaemia Leukaemia or any other blood/lymphatic system disorder					
16	Psychiatric/Mental illness or sleep disorder					
17	Any Congenital / Genetic disorders					
18	Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending					
19	Undertaken any lab/blood tests imaging tests viz scans/MRI in the last 5 years					
20	Been under any regular medication (self/ Prescribed)					
21	Any other ailment / injury / sickness for which underwent treatment or undergoing / contemplating					
22	Any type of organ transplanted					
23	Any other additional fact related to overall health & well being of insured person to be proposed for insurance and shall be disclose to the insurer and affect the decision of proposal accetance/ratings/loading,if any.					

Annexure: B

S No.	Name of Insured Person	Name of disease/injury	Treatment/medication received / receiving	Name of the Treating Doctor	Since When	Whether fully cured?
1						
2						
3						
4						
5						

* **Please attach an additional sheet for above details if required.**
* **Please attach complete discharge summary/supportive medical records, for all past claim cases/PED/Adverse health condition.**

Name of the Insured: Name of the Agent:

Signature of insured: Agent Signature:

Date: Agency Code:

For Office Use Only: SBU / LSC/BIMA SEVA KENDRA CODE: _____

Date of Acceptance: _____

Name of the UW/ accepting Officer: Signature of UW/ accepting officer