IFFCO-TOKIO GENERAL INSURANCE Muskurate Raho

Insured Declaration Form for Internal Health Product Conversion

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,

IMI to IHP (Individual Medishield to Individual Health Protector)	
IMI to FHP (Individual Medishield to Family health Protector)	
SKP to FHP (Swasthya Kavach To family health Protector)	
IHP to FHP (Individual Health Protector to Family Health Protector)	
SKP to IHP (Swasthya Jkavach To Individual Health Protector)	
Along with above selection, I also like to opt **Room Rent Waiver (RRW)** option too (On additional payment of 6 % of basic premium)	

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

Critical illness cover(On additional payment of 30% of Basic Premium)	
Change in Sum Insured	Existing Sum Insured :_______________ New Sum Insured :___________________

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.

Annexure (A & B) must be filled ONLY in case of Critical Illness coverage OR Sum Insured enhancement requested with past claim/s experience/ PED / change of Health Condition of any insured member/s.

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

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

IFFCO-TOKIO GENERAL INSURANCE
Muskurate Raho

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

Signature of insured:

Date:

Name of the Agent

Agent Signature:

Agency Code:

For Office Use Only:

SBU / LSC/BIMA KENDRACODE:______

Date of Acceptance: ____________________

Name of the accepting Officer:

Signature of the accepting officer