To,

Date:

The Manager
IFFCO Tokio General Insurance Co. Ltd.
4th Floor, IFFCO Bhavan,
Waterfield Road, Bandra,
Mumbai,
Maharashtra

Sub : Additional Declaration / Changes Required in the Proposal Form

Dear Sir/Madam,

Request you to kindly consider this as our declaration under the Proposal Form submitted to you while Porting to IFFCO TOKIO General Insurance Co. Ltd.
Expiring Policy Number : _____ Ported to ITGI
Expiry Date : __ /__ /2022

Please select the checkbox and provide the required details :

1. For Additional Declaration which was not submitted in the Proposal Form

☐ Additional Declaration w.r.t Health Declaration of any Insured Members

Section A : Have any of the persons proposed to be insured ever suffered from/ are currently suffering from any of the following :	Member name
i. High or low blood pressure	Yes☐No ☐
ii. Diabetes	Yes☐No ☐
iii. Chest pain, Ischemic heart disease or any other Heart disorder, Valve Related Disorder	Yes☐No ☐
iv. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint like ligament/meniscus tear etc	Yes☐No ☐
v. DUB, Fibroid, Cyst/Fibroadenoma or any other Gynaecological/Breast disorder	Yes☐No ☐
vi. Asthma / COPD or any other lung/Breathing disorder	Yes☐No ☐
vii. Tuberculosis	Yes☐No ☐

viii. Ulcer (stomach/duodenal), hepatitis, cirrhosis or any other Digestive or Liver/Gallbladder Disorder	Yes☐No ☐
ix. Renal failure, Kidney /ureteric stone or any other Kidney/Urinary tract or Prostate disorder	Yes☐No ☐
x. Dizziness, Stroke, Epilepsy(fits) , Paralysis or other brain/ nervous system disorder/ Multiple Sclerosis	Yes☐No ☐
xi. Thyroid disorder or any other endocrine disorder	Yes☐No ☐
xii. Tumor-benign or malignant, any ulcer/growth/cyst /mass or cancer	Yes☐No ☐

xiii. Diseases of the Nose/Ear/Throat/Teeth/ Eye (please mention Diopters for refractive errors	Yes☐No ☐
xiv. HIV/AIDS or sexually transmitted diseases or any immune system disorder	Yes☐No ☐
xv. Anaemia, Leukaemia or any other blood/lymphatic system disorder	Yes☐No ☐
xvi. Psychiatric/Mental illnesses or Sleep disorder	Yes☐No ☐
xvii. Any Congenital / Genetic disorders	Yes☐No ☐
xviii. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending	Yes☐No ☐
xix. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years	Yes☐No ☐
xx. Been under any regular medication (self/ prescribed)	Yes☐No ☐
xxi. Any other ailment / injury / sickness for which underwent treatment or undergoing /contemplating	Yes☐No ☐
xxii. Any type of organ transplanted	Yes☐No ☐

If your answer is YES, to any of the questions above, please provide details in the Table given below (Please use additional sheets if required

Sr. No	Name of Insured Person	Name of disease/injury	Treatment/medication received /receiving	Name of the Treating Doctor	Since When	Whether fully cured?

Thanking You
Yours Faithfully

Name & Signature of the Proposer

Encl :

Any other supporting document, please specify : _____