## **HDFC ERGO General Insurance Company Limited**

## my: Optima Secure - Optima Secure Global Plus - Proposal Form



1. Please fill the form in BLOCK LETTERS.  2. Please answer all the questions fully and correctly. If a particular question is not applicable to you, please mark that question as Not Application The Company's liability does not commence until the acceptance of the proposal has been formally intimated to the Policyholder and full premi realized by the Company.  Intermediary Code  Intermediary Name  Intermediary Number  PROPOSER DETAILS  Name of the Proposer:  Address:  Marital Status:  Contact Number:	
1. Please fill the form in BLOCK LETTERS.  2. Please answer all the questions fully and correctly. If a particular question is not applicable to you, please mark that question as Not Applica The Company's liability does not commence until the acceptance of the proposal has been formally intimated to the Policyholder and full premi realized by the Company.  Intermediary Code  Intermediary Name  Intermediary Number  PROPOSER DETAILS  Name of the Proposer:  Address:  Marital Status:  Contact Number:	ble "N/A".
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Intermediary Code Intermediary Name Intermediary Number  PROPOSER DETAILS  Name of the Proposer: Address: Contact Number:	um has beer
PROPOSER DETAILS  Name of the Proposer:  Address:  Marital Status:  Contact Number:	
Name of the Proposer:  Address:  Marital Status:  Contact Number:	
Name of the Proposer:  Address:  Marital Status:  Contact Number:	
Address:  Marital Status:  Contact Number:	
Marital Status: Contact Number:	
Permanent Account Number (PAN): I have eIA (Y/N): Yes No	
I would like to apply for eIA: Karvy CAMS NSDL CDSL Date of Birth: DDMMYYYYY	
Annual Income: 0-2.5 lakh 2.5 - 5 lakh 5 - 15 lakh 15 - 20 lakh 20-30 lakh 30 lakh and above	
Income proof: Email of the Proposer:	
Politically Exposed Person (Y/N): Yes No	
Occupation: Salaried Self-employed Student Professional Housewife Retired If Others (Please Specify	
	FSI
Real Estate Manufacturing if Others, please specify GSTIN / UIN (if any)	
Education Level:  Employee ID (Employees of HDFC Limited Group and Munich Re Group):	
Policy Number of any active HDFC ERGO Policy where you are the Policyholder:	
CKYC No Nationality:	
DETAILS OF THE PERSON(S) PROPOSED TO BE INSURED	
	ABHA ID f available)
1.	
3.       4.	
5.	
6.	
Note: In case any insured person(s) wish to generate his/her ABHA ID. Kindly visit the link: https://healthid.ndhm.gov.in/register	
DDEMILIM TIED (DI FASE TICK)	
PREMIUM TIER (PLEASE TICK)	
Tier 1 Tier 2 Classification of Cities for Premium Tier	

- Tier 1: Delhi, National Capital Region (NCR), Mumbai, Mumbai Suburban, Thane and Navi Mumbai, Surat, Ahmedabad and Vadodara.
- Tier 2: Rest of India

No co-payment shall apply if Insured Person from Tier 2 avails a treatment in Tier 1.

		NOMIN	EE DETAIL	S						
Name	of Person Proposed to be insured	Name of Nominee	Re	elationship		Δ	ddress o	f the No	minee	
Where	Nominee is a minor, please give the d				1					
	Name of the Appointee	Kela	ationship			Ad	aress ot	the Appo	ointee	
		Police	W DETAIL 6							
		POLIC	Y DETAILS							
Policy	Туре		Individu	ıal Family	/ Floater					
Tenur	e 		1 Year	2 Year	3 Ye	ar				
Policy	Period		From _		To					
		SUM IN	SURED IN	₹						
100 La	akhs		200 La	khs						
		OPTIO	NAL COVE	R						
S. No.	Ontiona	al Cover				D	eductible			
1	•	ravel Secure					NA			
				₹ 25,000	,	₹ 50,0	000	₹1	,00,000	
2		Deductible		₹ 2,00,00		₹ 3,00			5,00,000	
	(Applicable only for cla	ims arising within India)		₹ 10,00,0	00	₹ 20,0	0,000	₹2	25,00,000	o 🗌
	Neter									
	Note: a. Preventive health check-up ben	efit will not be available under	the policy	if Aggregate De	eductible	of INR 5	Lakhs is	in force.		
	b. Preventive Health Check-up, Se Unlimited Restore (Add-on) ben									
	Omminiou Needers (Nau en paen						2 241110			•
		-	ON COVERS				<u> </u>		<del>-</del>	
	my: health Critical Illness (You can op 500 Lakhs)	t for a Sum Insured from 1 Lakh	ı to	Plan 1 (9 Illnesses)	<b>I</b>	lan 2 Inesses)	1	lan 3 nesses)	1	an 4 nesses)
				Plan 5	+ '	lan 6	+ `	lan 7	(	
				(25 Illnesses	s) (40 II	lnesses)	(51 III	nesses)		
2	Individual Personal Accident Rider			Yes No	o 🗌					
3	Unlimited Restore (Add-on)			Yes No	o 🗌					
4	my:health Hospital Cash Benefit			Yes No	o 🗍					
4 (a)	Hospital Cash benefit – Global (Optio	nal cover)		Yes No	o 🗍					
S.	Name	^IPA Rider	*,max.r. la -	olth Critical	m		ital C!	Pone#*	Cum Inc	urad Dav
No.	Nante	^IPA Rider Sum Insured in ₹		alth Critical Sum Insured	my: nea			Benefit : nsured in		irea Per
					1,000	2,000	3,000	5,000	7,500	10,000
1.										
2.										
3. 4.										
5.										
6.										

Sum Insured for add-on covers is on individual basis only (except for Unlimited Restore (Add on)

 $<sup>^{*}</sup>$ my: health Critical Illness add-on can be opted by adults (persons over 18 years of age) only

<sup>^</sup> Sum Insured under Individual Personal Accident rider will be 5 (five) times the Sum Insured of my: Optima Secure (Base Plan) up to a maximum of Rs. 1 Crore and this rider will be offered only to the Proposer

## **EXISTING/PREVIOUS INSURANCE POLICY DETAILS**

Does any person proposed to be insured presently hold any Health Insurance/Critical Illness Insurance Policies from HDFC ERGO or any other Insurer? If Yes, please provide below details

Policy No. / Application No.	Name of the Insured	Name of the Insurer	DD/MM/	Insurance YYYY To M/YYYY	Sum Insured	Claims lodged during the preceding years (Y/N)	To be considered for continuity (Y/N)

	nuity of benefits shall NOT Migration details and relev		•		uity is not replied	l affirmative, details	are not provided
If No, please tick bel	ow declaration:						
	are on my behalf and on b or any other insurer.	ehalf of all persons pro	oposed to be insi	ured that I/We do	o not hold any He	ealth Insurance / Cri	tical Illness Policy
		MEDICAL AN	D LIFESTYLE IN	FORMATION			
(PLEAS	E PROVIDE INFORMATION	ON IN THE SAME ORD	DER AS MENTIO	NED UNDER PR	OPOSED PERSO	ONS TO BE INSURI	ED)
	YLE QUESTIONS FOR PER FOR EACH PERSON PRO						
INSURED 1							
Please select Medic	al Question for <name of="" th="" th<=""><th>ne person proposed to</th><td>be insured&gt;</td><td></td><td></td><td></td><td></td></name>	ne person proposed to	be insured>				
☐ 1. Has an ailment	or disability or deformity ir	ncluding due to accide	nt or congenital	disease			
☐ 2. Has planned a	surgery						
☐ 3. Takes medicine	es regularly						
☐ 4. Has been advis	sed investigation or further	tests					
☐ 5. Was hospitalize	ed in the past						
☐ 6. Is Pregnant	·						
☐ 7. None of the abo	ove						
ADDITIONAL MEDI	CAL QUESTIONS [RELEVA	ANT SECTION TO BE I	DISPLAYED WHE	N ANSWERED Y	ES IN PREVIOUS	S QUESTION]	
Please tick additiona  Hypertension/ High  Diabetes/ High bl  Cancer, Tumour, C  Chest Pain/ Heart  Liver or Gall Blad  Kidney ailment or  Tuberculosis/ Astl  Ulcer (Stomach/ D  Any Blood disord	disability or deformity \( \text{\ti}\text{\texi{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tex{	Disease/ Problem atitis B or Corgans order of Digestive System					

 $\square$  Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)  $f\square$  Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders  $\square$  Eye or vision disorders/ Ear/ Nose or Throat diseases  $\square$  Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage  $\square$  Any other disease/condition not mentioned above Please share details for your ailment **Exact Diagnosis:** Diagnosis Date: Consultation Date: Hospital Name: Please share details of your treatment:

					·	$\neg$
2. Has planned a surg	ery 🛮 Yes 🗖	No. If Yes, pleas	se provide the be	elow details		
Please share details of						
Exact Diagnosis:			1			
Diagnosis Date:			Consultation D	nato:		
_			Consultation D	ate.		
Hospital Name:						
Proposed Surgery:						
Please share details o	f your past s	urgery <name of<="" td=""><td>the person prop</td><td>osed to be insured</td><td>·ed&gt;</td><td></td></name>	the person prop	osed to be insured	·ed>	
3. Takes medicines re	aularly 🗖 Vo	s∏ No If Ves n	lease provide the	a halow datails		
Please share details for			•		ao incurad	
	or your currer	it medication <	iaille of the perso	on proposed to be	Je ilisuleu>	
Exact Diagnosis:			0 11 11 15			
Diagnosis Date:			Consultation D	ate:		
Medicine Name:						
Please share details o	f your treatm	ent <name of="" td="" the<=""><td>e person propos</td><td>ed to be insured&gt;</td><td>&gt;</td><td> </td></name>	e person propos	ed to be insured>	>	
4. Has been advised i	nvestigation	or further tests [	☐ Yes ☐ No. If Ye	es, please provide	e the below details	
Please provide details	about inves	igation suggest	ed by your Docto	or <name of="" pe<="" td="" the=""><td>person proposed to be insured&gt;</td><td></td></name>	person proposed to be insured>	
Date of tests:		Type of	tests:			
Findings of tests:						
Please upload the inv	estigation tes	ts results				
						$\dashv$
5. Was hospitalized in	•	• •	•			
Please share details for	or your past r	nedical conditio	<b>n</b> <name of="" p<="" td="" the=""><td>erson proposed to</td><td>to be insured&gt;</td><td></td></name>	erson proposed to	to be insured>	
Exact Diagnosis:						
Diagnosis Date:			Consultation D	ate:		
Hospital Name:						
Please share details of	f your past m	edical condition	1			
6. Is Pregnant ☐ Yes [	☐ No. If Yes,	olease provide t	he below details			
	,	·				
Please share your exp	ected delive	ry date with us				
7. Are you having any	disability/ de	formity including	g accidental or c	ongenital?   Yes	s 🗆 No	
If Yes, Kindly tick the	-	-	_	ogoa = 100	· =	
☐ Amputation	e specific bo.	kes triat are app	iicabie.			
☐ Musculoskeletal	/ Locomotor					
☐ Neurological / C						
☐ Polio						
☐ Spinal cord						
☐ Stroke						
☐ Visual / Hearing	disability					
☐ Others						
Kindly providea det	ailed descrip	tionfor all boxes	ticked above:			
LIFESTYLE QUESTIO	NS [RELEVA	NT SECTION TO	BE FILLED]			
☐ Cigarette(s)	Per Day	PerWeek	Per Month	since past	years	
☐ Bidi(s)	Per Day	PerWeek	Per Month	since past	years	
☐ Tobacco Pouches	Per Day	PerWeek	Per Month	since past	years	
☐ Gutka Pouches	Per Day	PerWeek	Per Month	since past	vears	
☐ Alcohol (Quantity)	Per Day	PerWeek	Per Month	since past	-	
☐ Drugs_(Quantity)	Per Day	PerWeek	Per Month	since past	·	
3 = 1 1 1 1 1 1 1	- ,				<u> </u>	
(DI EASE	PPOVIDE IN	IEOPMATION IN		ND LIFESTYLE INF	NFORMATION DNED UNDER PROPOSED PERSONS TO BE INSURED)	
(I LEASE	TROVIDE	I ORMATION II	THE SAME ON	DEICAS MEITHOR	WED ONDER I NOT COED I ENCORED TO DE INCORED,	
MEDICAL & LIFESTYI						
INSURED 2						
	Ougstion for	<pre></pre>	roop proposed t	o ho inquirod>		
Please select Medical						
☐ 1. Has an ailment or	-	deformity includ	ling due to accid	ent or congenital c	I disease	
2. Has planned a su						
☐ 3. Takes medicines						
4. Has been advise	d investigation	on or further test	:s			
☐ 5. Was hospitalized	in the past					
☐ 6. Is Pregnant						
☐ 7. None of the above	/e					

ADDITIONAL MEDICAL QUESTIONS [RELEVANT SECTION	TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]
1. Has an ailment or disability or deformity ☐ Yes ☐ No. If Ye Please tick additional information about your ailment for ☐ Hypertension/ High blood pressure ☐ Diabetes/ High blood sugar/Sugar in urine ☐ Cancer, Tumour, Growth or Cyst of any kind ☐ Chest Pain/ Heart Attack or any other Heart Disease/ Pro ☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C ☐ Kidney ailment or Diseases of Reproductive organs ☐ Tuberculosis/ Asthma or any other Lung disorder ☐ Ulcer (Stomach/ Duodenal), or any ailment of Digestive S ☐ Any Blood disorder (example Anaemia, Haemophilia, Tha ☐ HIV Infection/AIDS or Positive test for HIV ☐ Nervous, Psychiatric or Mental or Sleep disorder ☐ Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous dis ☐ Abnormal Thyroid Function/ Goiter or any Endocrine org ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases ☐ Arthritis, Spondylitis, Fracture or any other disorder of Mid ☐ Any other disease/condition not mentioned above Please share details for your ailment Exact Diagnosis:	blem  ystem alassaemia) or any genetic disorder  order (Brain/ Spinal Cord etc.) an disorders
	tation Date:
Hospital Name:	tation date.
Please share details of your treatment:	
,	a Abra Dadassa da Asila
2. Has planned a surgery ☐ Yes ☐ No. If Yes, please provid Please share details of surgery <name of="" person="" propose<="" td="" the=""><th></th></name>	
Exact Diagnosis:	ed to be insured>
	tation Date:
Hospital Name:	
Proposed Surgery:	
Please share details of your past surgery <name of="" pers<="" td="" the=""><th>on proposed to be insured&gt;</th></name>	on proposed to be insured>
2. Takes medicines regularly \( \Pi \) Ves \( \Pi \) No. If Ves. please pro	wide the helevy details
3. Takes medicines regularly \( \Boxed{\text{T}} \) Yes \( \Boxed{\text{No. If Yes, please properties}} \) Please share details for your current medication <name of="" t<="" td=""><th></th></name>	
Exact Diagnosis:	ne person proposed to be insured?
_	tation Date:
Medicine Name:	
Please share details of your treatment < name of the person	proposed to be insured>
4. Has been advised investigation or further tests $\square$ Yes $\square$	No. If Yes, please provide the below details
Please provide details about investigation suggested by yo	ur Doctor <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
Date of tests: Type of tests:	
Findings of tests:	
Please upload the investigation tests results	
5. Was hospitalized in past 🗆 Yes 🗖 No. If Yes, please prov	de the below details
Please share details for your past medical condition <name< td=""><th>of the person proposed to be insured&gt;</th></name<>	of the person proposed to be insured>
Exact Diagnosis:	
	tation Date:
Hospital Name:	
Please share details of your past medical condition	
6. Is Pregnant □ Yes □ No. If Yes, please provide the below	details
Please share your expected delivery date with us	
7. Are you having any disability/ deformity including accided If Yes, Kindly tick the specific boxes that are applicable:  Amputation  Musculoskeletal / Locomotor  Neurological / Cerebral Palsy  Polio  Spinal cord  Stroke  Visual / Hearing disability  Others  Kindly provides detailed descriptionfor all boxes ticked a	

LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]						
☐ Cigarette(s)	Per Day_	PerWeek	Per Month	since past	years	
☐ Bidi(s)	Per Day	PerWeek	Per Month	since past	years	
☐ Tobacco Pouches	Per Day_	PerWeek	Per Month	since past	years	
☐ Gutka Pouches	Per Day_	PerWeek	Per Month	since past	years	
☐ Alcohol (Quantity)	Per Day_	PerWeek	Per Month	since past	years	
☐ Drugs_(Quantity)	Per Day_	PerWeek	Per Month	since past	years	

MEDICAL AND LIFESTYLE INFORMATION (PLEASE PROVIDE INFORMATION IN THE SAME ORDER AS MENTIONED UNDER PROPOSED PERSONS TO BE INSURED)
MEDICAL & LIFESTYLE QUESTIONS FOR PERSON PROPOSED TO BE INSURED
[TO BE REPEATED FOR EACH PERSON PROPOSED TO BE INSURED] INSURED 3
Please select Medical Question for <name be="" insured="" of="" person="" proposed="" the="" to="">  1. Has an ailment or disability or deformity including due to accident or congenital disease 2. Has planned a surgery 3. Takes medicines regularly 4. Has been advised investigation or further tests 5. Was hospitalized in the past 6. Is Pregnant 7. None of the above</name>
ADDITIONAL MEDICAL QUESTIONS [RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]
1. Has an ailment or disability or deformity
Please share details of your treatment:
2. Has planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details  Please share details of surgery <name be="" insured="" of="" person="" proposed="" the="" to="">  Exact Diagnosis:  Diagnosis Date: Consultation Date:  Hospital Name:  Proposed Surgery:  Please share details of your past surgery <name be="" insured="" of="" person="" proposed="" the="" to=""></name></name>
3. Takes medicines regularly  \( \text{ Yes} \) No. If Yes, please provide the below details  Please share details for your current medication <name be="" insured="" of="" person="" proposed="" the="" to="">  Exact Diagnosis:  Diagnosis Date: Consultation Date:  Medicine Name:  Please share details of your treatment <name be="" insured="" of="" person="" proposed="" the="" to=""></name></name>
4. Has been advised investigation or further tests  No. If Yes, please provide the below details  Please provide details about investigation suggested by your Doctor <name be="" date="" findings="" insured="" investigation="" of="" person="" please="" proposed="" results<="" td="" tests="" tests:="" the="" to="" type="" upload=""></name>

5. Was hospitalized in	n past 🗖 Yes 🛭	☐ No. If Yes, plea	ase provide the b	elow details		
Please share details f	or your past n	nedical condition	n <name of="" p<="" td="" the=""><td>erson proposed to</td><td>be insured&gt;</td><td></td></name>	erson proposed to	be insured>	
Exact Diagnosis:						
Diagnosis Date:			Consultation D	ate:		
Hospital Name:						
Please share details of	of your past m	edical condition				
6. Is Pregnant ☐ Yes I	□ No. If Yes, p	please provide t	he below details			
Please share your exp	pected delive	ry date with us				
7. Are you having any If Yes, Kindly tick th Amputation Musculoskeletal Neurological / C Polio Spinal cord Stroke Visual / Hearing Others	ne specific box	kes that are appl	_	ongenital? 🗖 Yes	□ No	
Kindly providea det	tailed descrip	tionfor all boxes	ticked above:			
LIFESTYLE QUESTIO	NS [RELEVAI	NT SECTION TO	BE FILLED]			
☐ Cigarette(s)	Per Day	PerWeek	Per Month	since past	years	
☐ Bidi(s)	Per Day	PerWeek	Per Month	since past	years	
☐ Tobacco Pouches	Per Day	PerWeek	Per Month	since past	years	
☐ Gutka Pouches	Per Day	PerWeek	Per Month	since past	years	
☐ Alcohol (Quantity)	Per Day	PerWeek	Per Month	since past	years	
☐ Drugs_(Quantity)	Per Day	PerWeek	Per Month	since past	years	
			MEDICAL AN	ND LIFESTYLE INF	OPMATION	
(PLEASE	PROVIDE IN	IFORMATION IN				D PERSONS TO BE INSURED)
MEDICAL & LIFESTY						
[TO BE REPEATED FO	OR EACH PER	RSON PROPOSI	ED TO BE INSUR	RED]		
TO BE REPEATED FO	OR EACH PER	rson Proposition	erson proposed t	o be insured>	lisease	
ITO BE REPEATED FO INSURED 4  Please select Medical  □ 1. Has an ailment o  □ 2. Has planned a select Medical	I Question for r disability or urgery	rson Proposition	erson proposed t	o be insured>	lisease	
INSURED 4  Please select Medical  1. Has an ailment o	I Question for r disability or urgery	<pre>c<name of="" per<="" pre="" the=""></name></pre>	erson proposed t	o be insured>	lisease	
ITO BE REPEATED FO INSURED 4  Please select Medical  □ 1. Has an ailment o  □ 2. Has planned a select Medical	I Question for r disability or urgery	Name of the pedeformity included.	erson proposed ting due to accide	o be insured>	lisease	
ITO BE REPEATED FO INSURED 4  Please select Medical  □ 1. Has an ailment o  □ 2. Has planned a si  □ 3. Takes medicines	I Question for r disability or urgery s regularly ed investigation	Name of the pedeformity included.	erson proposed ting due to accide	o be insured>	lisease	
Please select Medical  1. Has an ailment o  2. Has planned a si  3. Takes medicines  4. Has been advise	I Question for r disability or urgery s regularly ed investigation	Name of the pedeformity included.	erson proposed ting due to accide	o be insured>	lisease	
ITO BE REPEATED FOR INSURED 4  Please select Medical  □ 1. Has an ailment o  □ 2. Has planned a si  □ 3. Takes medicines  □ 4. Has been advise  □ 5. Was hospitalized	I Question for a disability or urgery a regularly ed investigation in the past	Name of the pedeformity included.	erson proposed ting due to accide	o be insured>	lisease	
Please select Medical  1. Has an ailment o  2. Has planned a si  3. Takes medicines  4. Has been advise  5. Was hospitalized  6. Is Pregnant  7. None of the abox	I Question for a disability or urgery a regularly ed investigation d in the past executed we we we were all QUESTION	<name further="" included="" of="" on="" or="" p="" pedeformity="" test<="" the=""> NS [RELEVANT :</name>	erson proposed ting due to accide s	o be insured> ent or congenital c	N ANSWERED YES IN P	REVIOUS QUESTION]
ITO BE REPEATED FOR INSURED 4  Please select Medical  □ 1. Has an ailment o  □ 2. Has planned a si  □ 3. Takes medicines  □ 4. Has been advise  □ 5. Was hospitalized  □ 6. Is Pregnant  □ 7. None of the above  ADDITIONAL MEDIC.  1. Has an ailment or d  Please tick additional  □ Hypertension/ High  □ Diabetes/ High blo  □ Cancer, Tumour, Gr  □ Chest Pain/ Heart A  □ Liver or Gall Bladde  □ Kidney ailment or D  □ Tuberculosis/ Asthr  □ Ulcer (Stomach/ Du  □ Any Blood disorder  □ HIV Infection/AIDS  □ Nervous, Psychiatr  □ Stroke/ Paralysis/ E  □ Abnormal Thyroid I	I Question for a disability or urgery a regularly ed investigation of in the past of in the past of information and blood pression of sugar/Sugarowth or Cyst Attack or any der ailment/Jau Diseases of Rema or any oth uodenal), or air (example An or Positive tegic or Mental of Epilepsy (Fits) Function/ Goit	NS [RELEVANT:  NS [RELEVANT:  formity   Yes    about your ailmed  for any kind  other Heart Dise  ure  ure  ure  ure  ure  ure  ure  u	erson proposed to ling due to accide serson proposed to ling ling ling ling ling ling ling ling	o be insured> ent or congenital c	N ANSWERED YES IN Pow details	REVIOUS QUESTION]
INSURED 4  Please select Medical  1. Has an ailment o  2. Has planned a si  3. Takes medicines  4. Has been advise  5. Was hospitalized  6. Is Pregnant  7. None of the abov  ADDITIONAL MEDIC.  1. Has an ailment or d  Please tick additional  Hypertension/ High  Diabetes/ High blo  Cancer, Tumour, Gr  Chest Pain/ Heart A  Liver or Gall Bladdd  Kidney ailment or D  Tuberculosis/ Asthr  Ulcer (Stomach/ Dt  Any Blood disorder  HIV Infection/AIDS  Nervous, Psychiatr  Stroke/ Paralysis/ E  Abnormal Thyroid I  Eye or vision disord  Arthritis, Spondyliti  Any other disease/	I Question for r disability or urgery s regularly ed investigation d in the past we  AL QUESTION  Isability or device information and blood pressure of sugar/Sugar with or Cyst Attack or any der ailment/Jau Diseases of Rema or any other and or Positive tegic or Mental of Epilepsy (Fits) Function/ Gorders/ Ear/ Nosis, Fracture or recondition not	In a continue of the period of	erson proposed to thing due to accide to securify the securify the securification of the	o be insured> ent or congenital c	N ANSWERED YES IN Pow details  disorder	REVIOUS QUESTION]
INSURED 4  Please select Medical  1. Has an ailment o  2. Has planned a si  3. Takes medicines  4. Has been advise  5. Was hospitalized  6. Is Pregnant  7. None of the abov  ADDITIONAL MEDIC.  1. Has an ailment or d  Please tick additional  Hypertension/ High  Diabetes/ High blo  Cancer, Tumour, Gr  Chest Pain/ Heart A  Liver or Gall Bladde  Kidney ailment or D  Tuberculosis/ Asthr  Ulcer (Stomach/ Du  Any Blood disorder  HIV Infection/AIDS  Nervous, Psychiatr  Stroke/ Paralysis/ E  Abnormal Thyroid I  Eye or vision disord  Arthritis, Spondyliti  Any other disease/ Please share details for	I Question for r disability or urgery s regularly ed investigation d in the past we  AL QUESTION  Isability or device information and blood pressure of sugar/Sugar with or Cyst Attack or any der ailment/Jau Diseases of Rema or any other and or Positive tegic or Mental of Epilepsy (Fits) Function/ Gorders/ Ear/ Nosis, Fracture or recondition not	In a continue of the period of	erson proposed to thing due to accide to securify the securify the securification of the	o be insured> ent or congenital c	N ANSWERED YES IN Pow details  disorder	REVIOUS QUESTION]
INSURED 4  Please select Medical  1. Has an ailment o  2. Has planned a si  3. Takes medicines  4. Has been advise  5. Was hospitalized  6. Is Pregnant  7. None of the abov  ADDITIONAL MEDIC.  1. Has an ailment or d  Please tick additional  Hypertension/ High  Diabetes/ High blo  Cancer, Tumour, Gr  Chest Pain/ Heart A  Liver or Gall Bladdd  Kidney ailment or D  Tuberculosis/ Asthr  Ulcer (Stomach/ Dt  Any Blood disorder  HIV Infection/AIDS  Nervous, Psychiatr  Stroke/ Paralysis/ E  Abnormal Thyroid I  Eye or vision disord  Arthritis, Spondyliti  Any other disease/	I Question for r disability or urgery s regularly ed investigation d in the past we  AL QUESTION  Isability or device information and blood pressure of sugar/Sugar with or Cyst Attack or any der ailment/Jau Diseases of Rema or any other and or Positive tegic or Mental of Epilepsy (Fits) Function/ Gorders/ Ear/ Nosis, Fracture or recondition not	In a continue of the period of	erson proposed to thing due to accide to securify the securify the securification of the	DISPLAYED WHEN the provide the below the provide the provide the below the provide the below the provide the provide the provide the below the provide the provi	N ANSWERED YES IN Pow details  disorder	REVIOUS QUESTION]

Please share details of your treatment:

2. Has planned a surg	ery 🛮 Yes 🗖	No. If Yes, pleas	se provide the be	elow details		
Please share details o						
Exact Diagnosis:						
Diagnosis Date:			Consultation D	ate:		
Hospital Name:						
Proposed Surgery:						
Please share details o	f your past sı	urgery <name of<="" td=""><td>the person prop</td><td>osed to be insure</td><td>ed&gt;</td><td></td></name>	the person prop	osed to be insure	ed>	
3. Takes medicines reg	gularly 🗖 Yes	s 🗖 No. If Yes, p	lease provide the	e below details		
Please share details for	or your currer	nt medication <	name of the perso	on proposed to be	e insured>	
Exact Diagnosis:						
Diagnosis Date:			Consultation D	ate:		
Medicine Name:						
Please share details o	f your treatm	ent <name of="" td="" th<=""><td>e person propos</td><td>ed to be insured&gt;</td><td>&gt;</td><td></td></name>	e person propos	ed to be insured>	>	
4. Has been advised in	_					
· ·	about invest			or <name of="" pe<="" td="" the=""><td>person proposed to be insured&gt;</td><td></td></name>	person proposed to be insured>	
Date of tests:		Type of	tests:			
Findings of tests:						
Please upload the inve	estigation tes	its results				
5. Was hospitalized in	-	•	•			
Please share details fo	or your past n	nedical conditio	<b>n</b> <name of="" p<="" td="" the=""><td>erson proposed to</td><td>to be insured&gt;</td><td></td></name>	erson proposed to	to be insured>	
Exact Diagnosis:						
Diagnosis Date:			Consultation D	ate:		
Hospital Name: Please share details o	f vour pact m	odical condition	,			
	-					
6. Is Pregnant  Yes	☑ No. If Yes, p	olease provide t	he below details			
Please share your exp	ected delive	ry date with us				
7. Are you having any	disability/ de	formity includin	g accidental or c	ongenital?   Yes	s 🗆 No	
If Yes, Kindly tick the	e specific box	kes that are app	licable:			
☐ Amputation						
☐ Musculoskeletal ☐ Neurological / Ce						
☐ Polio	erebiai Faisy					
☐ Spinal cord						
☐ Stroke						
☐ Visual / Hearing ☐ Others	disability					
Kindly providea det	ailed descrip	tionfor all boxes	ticked above:			
LIFESTYLE QUESTION	•					
☐ Cigarette(s)	Per Day	PerWeek	Per Month	since past	Vears	
☐ Bidi(s)	Per Day	PerWeek PerWeek	Per Month	since past	•	
☐ Tobacco Pouches	Per Day	r erweek PerWeek	Per Month	since past	-	
☐ Gutka Pouches	Per Day	PerWeek	Per Month	since past	-	
☐ Alcohol (Quantity)	Per Day	PerWeek	Per Month	since past	•	
☐ Drugs_(Quantity)	Per Day	PerWeek	Per Month	since past	years	
			MEDICAL AN	ND LIFESTYLE INF	FORMATION	
(PLEASE	PROVIDE IN	FORMATION II			NED UNDER PROPOSED PERSONS TO BE INSURED)	
MEDICAL & LIFESTYL						
INSURED 5				RED]		
Diago coloct Madical	Ourstine for	6 th		- 1 1		

Please select Medical Question for<name of the person proposed to be insured>

 $f\square$  1. Has an ailment or disability or deformity including due to accident or congenital disease

lacksquare 2. Has planned a surgery

lacksquare 3. Takes medicines regularly

 $\ \square$  4. Has been advised investigation or further tests

 $\hfill \Box$  5. Was hospitalized in the past

lacksquare 6. Is Pregnant

lacksquare 7. None of the above

ADDITIONAL MEDICAL QUESTIONS [RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]
1. Has an ailment or disability or deformity  \ Yes \ No. If Yes, please provide the below details  Please tick additional information about your ailment for  Hypertension/ High blood pressure  Diabetes/ High blood sugar/Sugar in urine  Cancer, Tumour, Growth or Cyst of any kind  Chest Pain/ Heart Attack or any other Heart Disease/ Problem  Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C  Kidney ailment or Diseases of Reproductive organs  Tuberculosis/ Asthma or any other Lung disorder  Ulcer (Stomach/ Duodenal), or any ailment of Digestive System  Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder  HIV Infection/AIDS or Positive test for HIV  Nervous, Psychiatric or Mental or Sleep disorder  Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)  Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders  Eye or vision disorders/ Ear/ Nose or Throat diseases  Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage  Any other disease/condition not mentioned above  Please share details for your ailment  Exact Diagnosis:
Diagnosis Date: Consultation Date:
Hospital Name:
Please share details of your treatment:
2. Has planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details  Please share details of surgery <name be="" insured="" of="" person="" proposed="" the="" to="">  Exact Diagnosis:  Diagnosis Date:  Consultation Date:  Hospital Name:</name>
Proposed Surgery:
Please share details of your past surgery <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
3. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details  Please share details for your current medication <name be="" insured="" of="" person="" proposed="" the="" to="">  Exact Diagnosis:  Diagnosis Date:  Medicine Name:  Please share details of your treatment <name be="" insured="" of="" person="" proposed="" the="" to=""></name></name>
4. Has been advised investigation or further tests $\square$ Yes $\square$ No. If Yes, please provide the below details
Please provide details about investigation suggested by your Doctor <name be="" insured="" of="" person="" proposed="" the="" to=""> Date of tests: Findings of tests:  Please upload the investigation tests results</name>
5. Was hospitalized in past ☐ Yes ☐ No. If Yes, please provide the below details
Please share details for your past medical condition <name be="" insured="" of="" person="" proposed="" the="" to="">  Exact Diagnosis:  Diagnosis Date:  Hospital Name:  Please share details of your past medical condition</name>
6. Is Pregnant ☐ Yes ☐ No. If Yes, please provide the below details
Please share your expected delivery date with us
7. Are you having any disability/ deformity including accidental or congenital?

LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]						
☐ Cigarette(s)	Per Day	PerWeek	Per Month	since past	years	
☐ Bidi(s)	Per Day	PerWeek	Per Month	since past	years	
☐ Tobacco Pouches	Per Day	PerWeek	Per Month	since past	years	
☐ Gutka Pouches	Per Day	PerWeek	Per Month	since past	years	
☐ Alcohol (Quantity)	Per Day	PerWeek	Per Month	since past	years	
☐ Drugs_(Quantity)	Per Day	PerWeek	Per Month	since past	years	

MEDICAL AND LIFESTYLE INFORMATION (PLEASE PROVIDE INFORMATION IN THE SAME ORDER AS MENTIONED UNDER PROPOSED PERSONS TO BE INSURED)					
MEDICAL & LIFESTYLE QUESTIONS FOR PERSON PROPOSED TO BE INSURED					
[TO BE REPEATED FOR EACH PERSON PROPOSED TO BE INSURED] INSURED 6					
Please select Medical Question for <name be="" insured="" of="" person="" proposed="" the="" to="">  □ 1. Has an ailment or disability or deformity including due to accident or congenital disease  □ 2. Has planned a surgery  □ 3. Takes medicines regularly  □ 4. Has been advised investigation or further tests  □ 5. Was hospitalized in the past  □ 6. Is Pregnant  □ 7. None of the above  ADDITIONAL MEDICAL QUESTIONS [RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]  1. Has an ailment or disability or deformity □ Yes □ No. If Yes, please provide the below details  Please tick additional information about your ailment for  □ Hypertension/ High blood pressure  □ Diabetes/ High blood sugar/Sugar in urine</name>					
□ Cancer, Tumour, Growth or Cyst of any kind □ Chest Pain/ Heart Attack or any other Heart Disease/ Problem □ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C □ Kidney ailment or Diseases of Reproductive organs □ Tuberculosis/ Asthma or any other Lung disorder □ Ulcer (Stomach/ Duodenal), or any ailment of Digestive System □ Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder □ HIV Infection/AIDS or Positive test for HIV □ Nervous, Psychiatric or Mental or Sleep disorder □ Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.) □ Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders □ Eye or vision disorders/ Ear/ Nose or Throat diseases □ Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage □ Any other disease/condition not mentioned above					
Please share details for your ailment  Exact Diagnosis:					
Diagnosis Date: Consultation Date:  Hospital Name:  Please share details of your treatment:					
2. Has planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details					
Please share details of surgery <name be="" insured="" of="" person="" proposed="" the="" to="">  Exact Diagnosis:</name>					
Diagnosis Date: Consultation Date:  Hospital Name:  Proposed Surgery:  Please share details of your past surgery <name be="" insured="" of="" person="" proposed="" the="" to=""></name>					
3. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details					
Please share details for your current medication <name be="" insured="" of="" person="" proposed="" the="" to="">  Exact Diagnosis:</name>					
Diagnosis Date: Consultation Date:  Medicine Name:					
Please share details of your treatment <name be="" insured="" of="" person="" proposed="" the="" to=""></name>					
4. Has been advised investigation or further tests ☐ Yes ☐ No. If Yes, please provide the below details  Please provide details about investigation suggested by your Doctor <name be="" insured="" of="" person="" proposed="" the="" to="">  Date of tests:  Type of tests:  Findings of tests:  Please upload the investigation tests results</name>					

5. Was hospitalized in Please share details f					a ba insurad		
Exact Diagnosis:	or your past i	nedical conditio	ni <name or="" p<="" td="" the=""><td>person proposed to</td><td>be insured&gt;</td><td></td><td></td></name>	person proposed to	be insured>		
Diagnosis Date: Consultation Date:							
Hospital Name:							
Please share details of	of your past m	nedical condition	n				
6. Is Pregnant ☐ Yes I	□ No. If Yes,	please provide	the below details				
Please share your exp	pected delive	ry date with us					
7. Are you having any	disability/ de	eformity includin	ng accidental or c	ongenital? 🏻 Yes	□No		
If Yes, Kindly tick the specific boxes that are applicable:							
☐ Amputation ☐ Musculoskeletal	/ Locomotor						
☐ Neurological / C							
Polio							
☐ Spinal cord☐ Stroke							
☐ Visual / Hearing	disability						
☐ Others	•						
Kindly providea det	•						
LIFESTYLE QUESTIO	NS [RELEVA	NT SECTION TO	O BE FILLED]				
☐ Cigarette(s)	Per Day	PerWeek	Per Month	since past	years		
☐ Bidi(s)	Per Day	PerWeek	Per Month	·	-		
☐ Tobacco Pouches	Per Day	PerWeek	Per Month		-		
☐ Gutka Pouches	Per Day	PerWeek	Per Month	since past	-		
☐ Alcohol (Quantity) ☐ Drugs_(Quantity)	Per Day Per Day	PerWeek PerWeek	Per Month Per Month	since past	-		
□ Drugs_(Quantity)	rei Day	rerveek	Fer Month	since past	years		
			F	PAYMENT DETAIL	S		
Premium Details: Amo	ount Rs.						
Premium Payment Op	tions –Single	Monthly / Qua	rterly / Half Yearly	/ / Annual			
Premium Payment Op	tions - Chequ	ue / DD / Card /I	ECS/Wallet				
Instrument Details:		Date					
					MIUM/PPC REIMBU		
				D DIRECTLY INTO	YOUR BANK ACC	OUNT?	
* Cheque will be issued	d in the name	of the Propose	r only.				
	and a copy of	a Cancelled Ch	neque if you opt f				h cheque. Please provide the e should be of the same bank
Cheque No				Name as i	n Bank Account		
Bank Name				Bank Acco	ount No		
Branch Name				IFSC Code	e		
Cheque Date				MICR Cod	le		
Cheque Amount for ₹							

Note: The Proposer agrees and undertakes to intimate in writing to HDFC ERGO about any change in bank account details. If ECS is selected, please submit the standing instruction form available at our branches.

## DECLARATION, CONSENT& WARRANTY ON BEHALF OF ALL PERSON(S)PROPOSED TO BE INSURED

- I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.
- I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved under writing policy of the Insurance company and that the policy will come into force only after full receipt to the premium chargeable.
- I/We further declare that I/We 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.
- I/We declare and further consent to the company. Seeking medical information from any hospital who at any time has attended on the life to be insured/ proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application or insurance on the life to be assured/proposer has been made for the purpose

of underwriting the proposal and /or claim settlement.	in application of insurance on the life to be assured/proposer has been made for the purpose
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 Governmental and/o	• , ,
details, as are available in my/ our Ayushman Bharat Health. Service Provider/s of HDFC ERGO and/or with any Govern	We provide my/ our consent to access my/ our (all insured) medical and personal records Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable) mental and/or Regulatory authority for the sole purposes of underwriting my/ our proposa e/ us and/ or to comply with the applicable Law/ Regulations.
■ I hereby grant consent to Agent/Broker/Corporate Agent or	r any other licensed intermediary to share my KYC (Know your Customer) and customer due Company Limited for the purpose of my insurance proposal.
Signature of the Proposer:	Date:
Time:	Place:
has been realized by the company.  We are under no obligation to accept any proposal for insural Insurance Company Limited along with the premium paymer General Insurance Company Limited and does not result in a the Company's sole and absolute discretion and upon full reaby HDFC ERGO General Insurance Company Limited, such accompany Limited along with the date from which the insurant not be liable for any claim in respect of an event giving rise to not covered under this policy(Your proposal form will be considered warning: This policy shall be voidable at the option of any material particulars by the Proposer. Any person of a proposal for insurance containing any false information, or commits a fraudulent insurance act, which will render the prinsurance benefits.  Anti-Rebating Warning: As per Section 41 of the Insurance allow or offer to allow, either directly or indirectly, as an induction of risk relating to lives or property in India, any rebate of policy, nor shall any person taking out or renewing or continuting the published prospectus or tables of the insurer. Violation of may extend to Rs.10 Lakhs.	ance. The Proposer agrees that the receipt of the Proposal Form by HDFC ERGO General and does not tantamount to the acceptance of the Proposal for insurance by HDFC ERGO concluded contract of insurance. The acceptance of the Proposal for insurance shall be at dization of the premium payment. In the event of acceptance of the Proposal for insurance ceptance shall be specifically intimated to the Proposer by HDFC ERGO General Insurance acceptance shall become effective. HDFC ERGO General Insurance Company Limited shall a claim covered under the Policy of Insurance that has occurred prior to policy issuance is dered after HDFC ERGO General Insurance Company Limited receives premium payment.) of the Company in the event of mis-representation, mis-description or non-disclosure who, knowingly and with intent to fraud the insurance company or any other person, files conceals or the purpose of misleading, Information concerning any fact material thereto, olicy voidable at the sole discretion of the insurance company and result in a denial of Act 1938, as amended, the practice of rebating is prohibited, as follows: No person shall ement to any person to take out or renew or continue an insurance policy in respect to any the whole or part of the commission payable or any rebate of the premium shown on the ining a policy accept any rebate, except such rebate as may be allowed in accordance with if Section41 of the Insurance Act 1938, as amended, shall be punishable with a fine which
	ERNACULAR DECLARATION
Declaration in case the proposal is filled other than the Propose other than an agent/employee of the company)	er/the proposer sign in vernacular language/proposer is illiterate (to be certified by someone
(The content of this form and its particulars have been explaine	d by me in vernacular to the Proposer who has understood and confirmed the same.)
Name of the Translator:	Signature of the Translator:
Place:	Date:
Name of the insured:	Signature of the insured:
Place:	Date:
·····×···×	

	INTERMEDIARY DECLARATION
the contents of this Proposal Form, Including the na and response(s) submitted by him/her in this Propo Insurance between the Company and the Proposer untrue statement(s)/information/response(s) is/are to be furnished, the company shall have the right	(Full Name) in my capacity as an Insurance Advisor/iary/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all ature of the questions contained in this Proposal Form to the Proposer including statement(s), information sal Form to questions contained herein or any details sought here in will form the basis of the Contract of if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any contained in this Proposal Form/ including addendum(s), affidavits, statements, submissions, furnished/to vary the benefits which may be payable and further more if there has been a non-disclosure of any suant to this Proposal may be treated by the Company as null and void and all premiums paid under the
Signature of Intermediary:	Date:
Time:	Place:
	CHECK LIST
<ol> <li>ID Proof: Passport / Pan Card / Voter ID / Driving Lice</li> <li>Proof of residence: Telephone Bill / Bank Account St</li> <li>Age Proof: Proof of Age or proof of having Aadhaar</li> <li>Renewal notice with claim details</li> <li>Photocopies of all previous policies and endorsement</li> <li>Income proof documents [To be provided only if my: h</li> <li>ITRs for last 2 FY</li> <li>Salary slips for last 3 months</li> </ol>	atement / Letter from any recognized public authority Electricity Bill / Ration Card
Intermediary Code:	FOR OFFICE USE ONLY
·····›	<
	ACKNOWLEDGEMENT CUSTOMER COPY
Cheque No:	Cheque Date: towards payment of premium on behalf of HDFC ERGO General Insurance Company Ltd.
Date:	Signature & Seal:

and we shall have no liability to make any payment if premium is not received by us in full and in time, or is not realized. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 15 days.

HDFC ERGO General Insurance Company Limited, IRDAI Reg. No.146 CIN: U66030MH2007PLC177117. Registered & Corporate Office: 1st Floor, HDFC House, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400 020. Customer

decision is and always shall be in our sole and absolute discretion. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions