Health On

Proposal Form

HDFC ERGO

Proposal Number . : ______________________________

Bank Details (to be provided by the Bank)
Employee Code of RM__________ Customer Relationship Number _______________Branch Code
Customer Bank account Number ____________
The policy will be offered basis the information provided by you in this proposal form. You must disclose all facts relevant to all persons proposed to be insured. Any non-disclosure may result in forfeiture of the policy. We shall have no liability to make any payment under the policy if premium is not received by Us in full and in time, or is not realized or non-fulfillment of pre policy checkup. Please note all sections are mandatory

1. PROPOSER DETAILS

The Central Government has made Aadhaar & PAN No./Form 60 mandatory for availing financial services including Insurance. The Aadhaar & PAN details provided by you would be used for authentication of your identity. In case Aadhaar Number/Pan Number is not provided at the time of application, it is to be submitted within six months from the date of the application failing which it may have an impact on policy status and claim processing.

I understand that the Aadhaar/Virtual ID & PAN details provided by me would be used for authentication of my identity as per applicable law and I hereby give my consent to the company to authenticate my Aadhaar & PAN details & link them with all existing policies I may have or take in future. Yes ☐ No ☐

☐ I am not eligible for Pan Card and in lieu of the same, I am submitting a copy of Form 60.

Proposer : (Mr./Ms./Mrs.)			
	First Name	Middle Name	Last Name
Date of Birth (DD/MM/YYYY)			Gender: M F
Telephone		Mobile No.:	
GSTIN/ UIN (if any) of Policy Holder		E Mail :	
Aadhaar Number/Virtual ID		PAN No.	
In case you do not have your Aadhaar Number/Virtual ID please provide Aadhaar Acknowledgment Number below			
Aadhaar Acknowledgment No.			
Aadhaar Address:			
District:		City/Town :	
Pin Code:		State :	
Is your Current Address different from your Aadhaar address, Yes ☐ No ☐ If Yes, please provide your Current Address below			
Current Address:			
District:		City/Town :	
Pin Code:		State :	
Spouse Name (If applicable)			
	First Name	Middle Name	Last Name
Mother's Name			
	First Name	Middle Name	Last Name
Father's Name			
	First Name	Middle Name	Last Name

Note: Please mention your correct mobile number. In case mobile number mentioned in the Proposer details or any other details in this Proposal Form is not correct, please contact us immediately.

Please submit a certified copy of any of the below **Officially Verified Document (OVD)** in any of the following scenarios:

- You are not entitled to be enrolled for Aadhaar and PAN
- The address mentioned in your Aadhaar Card is not your current address

ID Proof Type : Passport ☐ Driving License ☐ Voter's Card ☐ NREGA Job Card ☐
If Others (Any document notified by Central Government), please specify____________________
ID Proof No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Highest Qualification: Under Matriculate ☐ Matriculate ☐ Graduate☐ Post-Graduate☐ Higher ☐

Profession: Salaried ☐ Self Employed ☐ Others ☐ Details ________________________________

Nationality __________________ Marital Status ___________________ Annual Income___________________

Do you want to save Planet Earth? The answer to the question is evident but the irony is we all choose wrong option. Here is chance to do right

In case multiple "Yes" options are chosen, the first option would be considered by default.

Go digital with verified & digitally signed documents accessible anytime, anywhere at my fingertips. Yes ☐ No ☐

I choose e-insurance account to view or download policy details from an Insurance Repository & hereby give my consent to share my KYC details including Aadhaar No. & PAN with the Insurance Repository. Yes ☐ No ☐

I choose to have a hard copy as a proof of my policy although it means I am being unprotective to the environment. Yes ☐ No ☐

HEALTHON/PF/274/JULY2023

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2. PLAN DETAILS

Coverage : Individual ☐ Family Floater ☐	Proposed Policy Period:	From	D	D	M	M	Y	Y	Y	Y	To	D	D	M	M	Y	Y	Y	Y

Policy Period: 1 Year ☐ 2 Year ☐ 3 Year ☐

3. DETAILS OF THE PERSON PROPOSED TO BE INSURED

HEALTH ON DETAILS

S. No.	Name of Insured Person	Height (cms)	Weight (kgs)	Relationship with Proposer	Gender* (M/F/)	Date of Birth (dd/mm/yyyy)	Occupation Class***	Mobile Number	Aadhaar Number	Basic Sum Insured **	Premium (Rs.)
1											
2											
3											
4											
5											
6											
										Total premium payable (including tax & cess)	

* Gender Code - M (Male), F(Female), T(Third Gender). ** Family Floater policy will have same Sum Insured for all members. (See brochure for floater policy details

RIDER DETAILS:

PLAN DETAILS	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Name of Insured Person						
Critical Advantage Rider Sum Insured (USD)##						
Critical Advantage Rider Premium (Rs.)						
Individual Personal Accident Rider Sum Insured (Rs.)^						
Individual Personal Accident Rider Premium (Rs.)						
Protector Rider (Y/N)						
Protector Rider Premium (Rs.)						
Hospital Daily Cash Rider Sum Insured (Rs.) (Tick whichever is opted)	☐ 1000 per day ☐ 2000 per day ☐ 3000 per day					
Hospital Daily Cash Rider Premium (Rs.)						
Total Premium (Rs)						

Total premium payable (including tax & cess) for Health On & Riders: _____

** Family Floater policy will have same Sum Insured for all members.

Critical Advantage rider will be offered if base policy Sum Insured is Rs. 10 lacs & above The rider will be offered on individual sum insured basis. Rider can be opted by adult dependent only if primary insured also opts for the same. In case of dependent children and dependent parents rider can be opted on all or none basis.

^ Sum Insured under Individual Personal Accident rider will be 5 (five) times the Sum Insured of Health On (Base Plan) up to a maximum of Rs. 1 Crore and this rider will be offered only to the Proposer.

***Occupation Class Description OC1-Persons working inside offices/shops without exposure to working in the open, manual labour or regular on-road travel. OC2 - Persons working outside office/shops involving mild manual work, supervision of manual labour or regular on-road travel. OC3- Semi or Unskilled workers, skilled laborers, low voltage electricians, drivers, automated machine operators with moderate to heavy manual work working in workshops or in the open. OC4- Police, occupation or nature of job involve working in mines, with explosive, oil/gas/metal/power or chemical production, professional sports, high voltage electricity, handling of heavy machinery or hazardous materials, heat or noise or working at heights or significant manual labor. OC5-Individuals with unearned income (rental or interest, pension, landlords). OC6-Armed forces, sea going vessels Crews, Aircraft pilots and cabin crews, Actors, Heavy vehicle drivers, Machine operators

4. NOMINEE DETAILS

Name_____ Relationship to Proposer _____

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. Nominee for any of the persons proposed to be insured shall be the Proposer.

5. MEDICAL AND LIFESTYLE QUESTIONS

Important: You must answer the following questions truthfully. Not doing so affects your coverage in case of a Claim.

Medical History: Please answer the below mentioned questions individually in Yes(Y)/No (N):
Note: If any of the below Medical conditions is answered as Yes (Y), please answer the Questions in Annexure A.

Section A : Have any of the person proposed to be insured ever suffered from/ are currently suffering from any of the following :		Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6
i.	HTN, Heart Disease, circulatory disorder, Dyslipidemia	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
ii.	Diabetes, Thyroid disorder, or any other endocrine disorders	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐

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iii.	Respiratory Disorders like Asthma, COPD, Bronchitis, TB	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
iv.	Nervous disorder, fits, stroke, or any psychiatric (mental) condition	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
v.	Any Tumor , Cancer, chronic long lasting diseases	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
vi.	Bone and joint disorders like arthritis, joint replacement, spinal problems etc.	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
vii.	Kidney or urinary tract stone, or any other kidney disease or prostate disorder (male only)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
viii.	Disorders of the stomach, liver, pancreas, intestine, gall bladder	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
ix.	Complications in earlier pregnancy/Breast or gynecological diseases (female only)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
x.	Any surgery in past or planned in future or on any ongoing medication	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xi.	Is any of the insured pregnant?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xii.	Any Eye (except visual disturbance), Ear, Nose, Throat disorders	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xiii.	Please specify if any other medical conditions						

Section B: Name, address, qualification and contact details of the family doctor, if any																																				
Name :																																						
Address :																																					
Qualification :																								Mob. No. :												
Phone No :													Email ID :																								

Section C: Do you or any of the Insured members	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6
Consume alcohol/tobacco in any form (if Yes, please answer the following)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
How many days in a week do you consume alcohol?						
Since how many years have you been smoking?						
How many Cigarettes/Bidi/Cigars do you smoke in a day?						
How many packets of chewing tobacco/pan masala/gutkha do you consume in a day?						

6. PORTABILITY

I want to avail Portability benefits. Y ☐/N ☐ (If 'Yes' please fill the Portability form and submit portability documents.

7. EXISTING/PREVIOUS INSURANCE DETAILS

Policy No./ Application No.	Insurer	Period of Insurance		Sum Insured (Rs.)	Claims lodged during the preceding years	Status of previous application(s) if any
		From	To			
		D D M M Y Y	D D M M Y Y			
		D D M M Y Y	D D M M Y Y			
		D D M M Y Y	D D M M Y Y			
		D D M M Y Y	D D M M Y Y			
		D D M M Y Y	D D M M Y Y			
		D D M M Y Y	D D M M Y Y			

8. PREMIUM PAYMENT DETAILS:

Payment Frequency for Health On: Lumpsum ☐ Monthly ☐ Half-yearly ☐ quarterly ☐

Payment Frequency of Riders: (Tick whichever is opted)

Critical Advantage Rider	Same as Health On _____	Lump sum payment _____
Individual Personal Accident Rider	Same as Health On _____	Lump sum payment _____
Protector Rider	Same as Health On _____	Lump sum payment _____
Hospital Daily Cash Rider	Same as Health On _____	Lump sum payment _____

Premium Payment Details

Instrument (Credit Card/ Bank Account)	Instrument Number	Instrument Date	Name of the Payor	Bank Name	IFSC code	Amount (Rs.)

In case Premium is more than Rs.50,000, please provide PAN details. ☐☐☐☐☐☐☐☐☐☐

Section 41 of Insurance Act 1938 as amended by Insurance Laws Amendment Act, 2015 (Prohibition of Rebates):

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 of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurers.
2. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.

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9. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS TO BE INSURED

I/ We 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/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 underwriting policy of the Insurance Company and that the policy will come into force only after full receipt of 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 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 for insurance on the life to be assured/ proposer has been made for the purpose of underwriting the proposal and/or claim settlement. • 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/ or Regulatory Authority.

I understand that the AMHI may terminate the policy immediately, on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation by any Insured Person or anyone acting on policy holder's behalf or on behalf of an Insured Person upon 30 days' notice by sending an endorsement to Insured Person's address shown in the Schedule. I confirm that I have read the brochure and understood all the terms and conditions, coverage's, and exclusion (related to: pre-existing diseases, waiting period and exclusion) and I accept them.

☐ Signature of Proposer: Time: | | | | Date: D D M M Y Y Place: _____

For detailed terms and conditions, please refer insurance policy document

10. SPECIFIED PERSON/AGENT`S DECLARATION

, _____(Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy.

I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

Specified Person Signature | Specified Person Code | Date: D D M M Y Y | Place: _____

11. VERNACULAR DECLARATION :

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent/ employee of the company).

Name of the Proposer : _____

The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same :

Signature of the Proposer : | Signature of the witness :

Date : _____ | Name of the witness :

Place : _____

12. PLEASE PROVIDE DETAILS OF YOUR BANK ACCOUNT (Required For all refunds, if any/Claims):

Please provide the following bank details and a copy of a cancelled cheque for direct credit into your bank account:
(Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly, in case premium payment is made through cheque using the same bank account the cancelled cheque is not mandatory)

Name as in Bank Account			
Bank Name:		**Bank Branch:**	
Bank Account number		**IFSC Code:**	
MICR Code			

Please note:

It is important for these electronic payment systems that the Policy Holders name in the Policy must exactly match with the name in the Bank Account records/details given above. In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required.

I agree and undertakes to intimate in writing to HDFC ERGO General Insurance Company Limited about any change in bank account details.

Signature Proposer:_____ Date_____

DISCLAIMER: HDFC ERGO General Insurance Company Limited shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation- failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder. Aforesaid NEFT transaction shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. HDFC ERGO General Insurance Company Limited shall be indemnified against any loss/damage/claims caused to HDFC ERGO General Insurance Company Limited in carrying out your aforesaid NEFT instructions.

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Annexure A

The below questionnaire is an addendum to the medical questions under Section A of Medical and Lifestyle questions. These are to be answered only if any of those questions is answered as Yes (Y).

Note: Please provide the supporting documents (Discharge summary if hospitalized/Doctor Consultation/Investigation reports/Follow up reports/biopsy reports) for the conditions answered as Yes(Y) for medical underwriting.

	Section A : Have any of the person proposed to be insured ever suffered from/ are currently suffering from any of the following :	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4	Insured Person 5	Insured Person 6
HTN, Heart Disease, circulatory disorder, Dyslipidemia	Hypertension	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Heart Failure	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Myocardial Infarction (Heart Attack)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Coronary Arterial Bypass Grafting (CABG or Heart Bypass)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Percutaneous Transluminal Coronary Angioplasty (PTCA or Coronary Angioplasty)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Atrial Septal Defect (ASD)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Ventricular Septal Defect (VSD)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Patent Ductus Arteriosus (PDA)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Ischaemic Heart Disease (IHD)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Obstructive sleep apnoea	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Left ventricular hypertrophy (LVH)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Hypotension (Low blood pressure)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Deep vein thrombosis (DVT)Varicose veins	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	LBBB	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Dyslipidemia	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Anemia	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Other Medical Condition						
Diabetes, Thyroid disorder, or any other endocrine disorders	Hypothyroidism	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Hyperthyroidism	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Diabetes	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Impaired Glucose Tolerance (IGT)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Impaired Fasting Glucose (IFG)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Gestational diabetes	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Other Medical Condition						
Respiratory Disorders like Asthma, COPD, Bronchitis, TB	Emphysema	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Chronic Bronchitis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Tuberculosis (TB)Bronchial asthma	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Allergic bronchitis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Bronchiectasis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Pneumonia	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Other Medical Condition						

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Nervous disorder, fits, stroke, or any psychiatric (mental) condition	Epilepsy (Seizures or Fits) Stroke	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Stroke (Brain Hemorrhage or Cerebro-vascular accident) Bipolar disorder	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Paralysis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Parkinsons disease	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Transient Ischemic Attack (TIA)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Cerebral palsy	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Mental retardation	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Migraine	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Anxiety	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	depression	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Other Medical Condition						
Any Tumor , Cancer, chronic long lasting diseases	Cancer	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Benign tumor	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Cyst/Mass/Growth	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Chronic Disease on medication	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Other Medical Condition						
Bone and joint disorders like arthritis, joint replacement, spinal problems etc	Rheumatoid Arthritis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Ankylosing spondylosis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Disc prolapse (PIVD or Spondylosis)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Polio	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Fracture	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Avascular Necrosis (AVN)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Other Medical Condition						
Kidney or urinary tract stone, or any other kidney disease or prostate disorder (male only)	Kidney (Renal) Failure	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Nephrotic Syndrome	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Nephritic syndrome	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Polycystic Kidney Disease	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Renal cyst	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Renal and ureteric calculus (Stone)Urinary tract infection (UTI)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Benign prostatic hypertrophy (BPH)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Other Medical Condition						

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Disorders of the stomach, liver, pancreas, intestine, gall bladder	Crohn's Disease	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Cirrhosis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Ulcerative Colitis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Hepatitis B	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Alcoholic liver disease, Fatty Liver (NASH or Non Alcoholic Steato Hepatitis)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Typhoid	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Hepatitis (Jaundice)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Gastroenteritis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Acid peptic disease (APD)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Gastro-oesophageal reflux disorder (GERD)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Cholelithiasis (Gall bladder stone)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Haemorrhoids (Piles)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Fissure in ano (Anal fissures)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Fistula in ano	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Hernia	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Intussusception (Intestinal obstruction)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Pancreatitis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Other Medical Condition						
Complications in earlier pregnancy/Breast or gynecological diseases (female only)	Polycystic Ovarian Disease	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Pelvic inflammatory disorder (PID)	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Fibroid uterus	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Ovarian cyst	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Prolapse uterus	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Fibroadenoma breast	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Hydrocele	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Ovarian/Uterine mass	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Endometriosis	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
	Other Medical Condition						
Any Eye (except visual disturbance), Ear, Nose, Throat disorders	Cataract, glaucoma, Opticneuritis, retinal detachment, conjunctivitis, squint, ptosis, otitis media, Deviated Nasal Septum, Otosclerosis, Hearing loss, nasal polyps, chronic sinusitis Any other disorder of Ear, Nose and Throat?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
Any surgery in past or planned in future or on any ongoing medication	Please specify the condition						
Is any of the insured pregnant? If yes please mention the expected date of delivery	Expected Date of delivery (DD/MM/YYYY)						

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Section B:

Insured Name	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Name and details of Illness/ Medicine/ Test/ Surgery/ Diopter grade (for questions answered as Yes in Section B & C above)						
Exact diagnosis						
Diagnosis date/year						
Date of last consultation/Follow up						
Frequency of Medicine in a day						
Has there been any complications/Recurrence for the disease						
Treatment in/out-patient and details of treatment given						
Doctor/Hospital Name and Phone No.						