# HDFC ERGO General Insurance Company Limited

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

| Application No. | |
|---|---|

Photograph

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 Applicable "N/A".

The Company's liability does not commence until the acceptance of the proposal has been formally intimated to the Policyholder and full premium has been realized by the Company.

| Intermediary Code | Intermediary Name | Intermediary Number |
|---|---|---|
| | | |

## PROPOSER DETAILS

Name of the Proposer:

Address:

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: D D M M Y Y Y Y

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) _____

Industry Type: Jewellery Import-Export Mining Shipping Scrap Dealing Agriculture Stock Broking BFSI 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

| S. No. | Name | Date of Birth | Gender (M/F/TG) | Height (in cms) | Weight (in kgs) | Relationship with Proposer | Politically Exposed person (Y / N) | ABHA ID (if available) |
|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 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

## 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.

## NOMINEE DETAILS

| Name of Person Proposed to be insured | Name of Nominee | Relationship | Address of the Nominee |
|---|---|---|---|
| | | | |
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Where Nominee is a minor, please give the details of Appointee

| Name of the Appointee | Relationship | Address of the Appointee |
|---|---|---|
| | | |
| | | |

## POLICY DETAILS

| | |
|---|---|
| **Policy Type** | Individual ☐ Family Floater ☐ |
| **Tenure** | 1 Year ☐ 2 Year ☐ 3 Year ☐ |
| **Policy Period** | From _____ To _____ |

## SUM INSURED IN ₹

| | |
|---|---|
| 100 Lakhs ☐ | 200 Lakhs ☐ |

## OPTIONAL COVER

| S. No. | Optional Cover | | Deductible |
|---|---|---|---|
| 1 | Overseas Travel Secure | ☐ | NA |
| 2 | Aggregate Deductible<br>(Applicable only for claims arising within India) | ☐ | ₹ 25,000 ☐ ₹ 50,000 ☐ ₹ 1,00,000 ☐<br>₹ 2,00,000 ☐ ₹ 3,00,000 ☐ ₹ 5,00,000 ☐<br>₹ 10,00,000 ☐ ₹ 20,00,000 ☐ ₹ 25,00,000 ☐ |
| | Note:<br>a. Preventive health check-up benefit will not be available under the policy if Aggregate Deductible of INR 5 Lakhs is in force.<br>b. Preventive Health Check-up, Secure Benefit, Cumulative Bonus / Plus Benefit, Automatic Restore Benefit, Daily Cash for Shared Room and Unlimited Restore (Add-on) benefits will not be available under the policy if Aggregate Deductible of INR 10 Lakhs or more is in force. | | |

## ADD-ON COVERS

| | | | | | |
|---|---|---|---|---|---|
| 1 | my: health Critical Illness (You can opt for a Sum Insured from 1 Lakh to 500 Lakhs) | Plan 1 (9 Illnesses) | Plan 2 (12 Illnesses) | Plan 3 (15 Illnesses) | Plan 4 (18 Illnesses) |
| | | Plan 5 (25 Illnesses) | Plan 6 (40 Illnesses) | Plan 7 (51 Illnesses) | |
| 2 | Individual Personal Accident Rider | Yes ☐ No ☐ | | | |
| 3 | Unlimited Restore (Add-on) | Yes ☐ No ☐ | | | |
| 4 | my:health Hospital Cash Benefit | Yes ☐ No ☐ | | | |
| 4 (a) | Hospital Cash benefit – Global (Optional cover) | Yes ☐ No ☐ | | | |

| S. No. | Name | ^IPA Rider Sum Insured in ₹ | *my: health Critical Illness Sum Insured | my: health Hospital Cash Benefit Sum Insured Per Day Sum Insured in ₹ | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 1,000 | 2,000 | 3,000 | 5,000 | 7,500 | 10,000 |
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| 4. | | | | | | | | | |
| 5. | | | | | | | | | |
| 6. | | | | | | | | | |

*my: health Critical Illness add-on can be opted by adults (persons over 18 years of age) only

^ 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

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

## 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 | Period of Insurance DD/MM/YYYY To DD/MM/YYYY | | Sum Insured | Claims lodged during the preceding years (Y/N) | To be considered for continuity (Y/N) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
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Please note that continuity of benefits shall NOT be considered if the above question of want of continuity is not replied affirmative, details are not provided and Portability form / Migration details and relevant supporting documents are not submitted.

**If No, please tick below declaration:**

☐ I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that I/We do not hold any Health Insurance / Critical Illness Policy from HDFC ERGO or any other insurer.

## 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 1**

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

☐ 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
☐ 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 of the person proposed to be insured>
Exact Diagnosis:
Diagnosis Date: Consultation Date:
Hospital Name:
Proposed Surgery:
Please share details of your past surgery <name of the person proposed to be insured>

3. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details
Please share details for your current medication <name of the person proposed to be insured>
Exact Diagnosis:
Diagnosis Date: Consultation 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 ☐ Yes ☐ No. If Yes, please provide the below details
Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>
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 provide the below details
Please share details for your past medical condition <name of the person proposed to be insured>
Exact Diagnosis:
Diagnosis Date: Consultation 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 accidental or congenital? ☐ Yes ☐ No

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 providea detailed descriptionfor all boxes ticked above: _____

**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 2**

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

- ☐ 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
☐ 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 of the person proposed to be insured>

Exact Diagnosis:

Diagnosis Date: Consultation Date:

Hospital Name:

Proposed Surgery:

Please share details of your past surgery <name of the person proposed to be insured>

3. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details

Please share details for your current medication <name of the person proposed to be insured>

Exact Diagnosis:

Diagnosis Date: Consultation 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 ☐ Yes ☐ No. If Yes, please provide the below details

Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>

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 provide the below details

Please share details for your past medical condition <name of the person proposed to be insured>

Exact Diagnosis:

Diagnosis Date: Consultation 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 accidental or congenital? ☐ Yes ☐ No

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 providea detailed descriptionfor all boxes ticked above: _____

**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 of the person proposed to be insured>
☐ 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
☐ 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 of the person proposed to be insured>
Exact Diagnosis:
Diagnosis Date: Consultation Date:
Hospital Name:
Proposed Surgery:
Please share details of your past surgery <name of the person proposed to be insured>

3. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details
Please share details for your current medication <name of the person proposed to be insured>
Exact Diagnosis:
Diagnosis Date: Consultation 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 ☐ Yes ☐ No. If Yes, please provide the below details
Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>
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 provide the below details

Please share details for your past medical condition <name of the person proposed to be insured>

Exact Diagnosis:

Diagnosis Date: Consultation 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 accidental or congenital? ☐ Yes ☐ No

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 providea detailed descriptionfor all boxes ticked above: _____

**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 4**

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

- ☐ 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
- ☐ 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 of the person proposed to be insured>
Exact Diagnosis:
Diagnosis Date: Consultation Date:
Hospital Name:
Proposed Surgery:
Please share details of your past surgery <name of the person proposed to be insured>

3. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details
Please share details for your current medication <name of the person proposed to be insured>
Exact Diagnosis:
Diagnosis Date: Consultation 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 ☐ Yes ☐ No. If Yes, please provide the below details
Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>
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 provide the below details
Please share details for your past medical condition <name of the person proposed to be insured>
Exact Diagnosis:
Diagnosis Date: Consultation 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 accidental or congenital? ☐ Yes ☐ No

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 providea detailed descriptionfor all boxes ticked above: _____

**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 5**

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

- ☐ 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
☐ 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 of the person proposed to be insured>

Exact Diagnosis:

Diagnosis Date: Consultation Date:

Hospital Name:

Proposed Surgery:

Please share details of your past surgery <name of the person proposed to be insured>

3. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details

Please share details for your current medication <name of the person proposed to be insured>

Exact Diagnosis:

Diagnosis Date: Consultation 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 ☐ Yes ☐ No. If Yes, please provide the below details

Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>

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 provide the below details

Please share details for your past medical condition <name of the person proposed to be insured>

Exact Diagnosis:

Diagnosis Date: Consultation 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 accidental or congenital? ☐ Yes ☐ No

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 providea detailed descriptionfor all boxes ticked above: _____

**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 of the person proposed to be insured>
☐ 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
☐ 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 of the person proposed to be insured>
Exact Diagnosis:
Diagnosis Date: Consultation Date:
Hospital Name:
Proposed Surgery:
Please share details of your past surgery <name of the person proposed to be insured>

3. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details
Please share details for your current medication <name of the person proposed to be insured>
Exact Diagnosis:
Diagnosis Date: Consultation 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 ☐ Yes ☐ No. If Yes, please provide the below details
Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>
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 provide the below details

Please share details for your past medical condition <name of the person proposed to be insured>

Exact Diagnosis:

Diagnosis Date: Consultation 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 accidental or congenital? ☐ Yes ☐ No

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 providea detailed descriptionfor all boxes ticked above: _____

**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 |

## PAYMENT DETAILS

| |
|---|
| Premium Details: Amount Rs. |
| Premium Payment Options –Single/Monthly / Quarterly / Half Yearly / Annual |
| Premium Payment Options - Cheque / DD / Card /ECS/Wallet |
| Instrument Details:_____ Date_____ |

## WOULD YOU LIKE YOUR REFUND (EXCESS PREMIUM/PPC REIMBURSEMENT) BY CHEQUE* ORCREDITED DIRECTLY INTO YOUR BANK ACCOUNT?

* Cheque will be issued in the name of the Proposer only.

In case of payment made through credit card therefunde amount would be reversed in Credit Card account directly or through cheque. Please provide the following bank details and a copy of a Cancelled Cheque if you opt 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)

| | | | |
|---|---|---|---|
| Cheque No | | Name as in Bank Account | |
| Bank Name | | Bank Account No | |
| Branch Name | | IFSC Code | |
| Cheque Date | | MICR Code | |
| 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.
- 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.
- Ayushman Bharat Health Account (ABHA) Declaration : I/We provide my/ our consent to access my/ our (all insured) medical and personal records/ details, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider/s of HDFC ERGO and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations.
- I hereby grant consent to Agent/Broker/Corporate Agent or any other licensed intermediary to share my KYC (Know your Customer) and customer due diligence information with HDFC ERGO General Insurance Company Limited for the purpose of my insurance proposal.

Signature of the Proposer: _____ Date: _____

Time: _____ Place: _____

**Note:** The liability of the company does not commence until the acceptance of the proposal has been formally intimated by the insured and full premium has been realized by the company.
We are under no obligation to accept any proposal for insurance. The Proposer agrees that the receipt of the Proposal Form by HDFC ERGO General Insurance Company Limited along with the premium payment does not tantamount to the acceptance of the Proposal for insurance by HDFC ERGO General Insurance Company Limited and does not result in a concluded contract of insurance. The acceptance of the Proposal for insurance shall be at the Company's sole and absolute discretion and upon full realization of the premium payment .In the event of acceptance of the Proposal for insurance by HDFC ERGO General Insurance Company Limited, such acceptance shall be specifically intimated to the Proposer by HDFC ERGO General Insurance Company Limited along with the date from which the insurance Cover shall become effective. HDFC ERGO General Insurance Company Limited shall not be liable for any claim in respect of an event giving rise to a claim covered under the Policy of Insurance that has occurred prior to policy issuance is not covered under this policy(Your proposal form will be considered after HDFC ERGO General Insurance Company Limited receives premium payment.)
**Fraud Warning:** This policy shall be voidable at the option of the Company in the event of mis-representation, mis-description or non-disclosure of any material particulars by the Proposer. Any person who, knowingly and with intent to fraud the insurance company or any other person, files a proposal for insurance containing any false information, or conceals or the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, which will render the policy voidable at the sole discretion of the insurance company and result in a denial of insurance benefits.
**Anti-Rebating Warning:** As per Section 41 of the Insurance Act 1938,as amended, the practice of rebating is prohibited, as follows: 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 policy in respect to 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 prospectus or tables of the insurer. Violation of Section41 of the Insurance Act 1938, as amended, shall be punishable with a fine which may extend to Rs.10 Lakhs.

## VERNACULAR DECLARATION

Declaration in case the proposal is filled other than the Proposer/the proposer sign in vernacular language/proposer is illiterate (to be certified by someone other than an agent/employee of the company)

(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.)

Name of the Translator: _____ Signature of the Translator: _____

Place: _____ Date: _____

Name of the insured: _____ Signature of the insured: _____

Place: _____ Date: _____

## INTERMEDIARY DECLARATION

I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Intermediary/Authorized 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 here in 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 favor 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.

Signature of Intermediary: _____ Date: _____

Time: _____ Place: _____

## CHECK LIST

**Please check the following documents are attached along with the proposal form**

1. ID Proof : Passport / Pan Card / Voter ID / Driving License / Letter from a recognized public authority
2. Proof of residence : Telephone Bill / Bank Account Statement / Letter from any recognized public authority Electricity Bill / Ration Card
3. Age Proof : Proof of Age or proof of having Aadhaar
4. Renewal notice with claim details
5. Photocopies of all previous policies and endorsements
6. Income proof documents [To be provided only if my: health Critical Illness add-on cover is opted]
   - ITRs for last 2 FY
   - Salary slips for last 3 months

## FOR OFFICE USE ONLY

Intermediary Code: _____ Branch Location: _____

Signature of Intermediary: _____

## ACKNOWLEDGEMENT CUSTOMER COPY

Received from Mr. / Ms. / Mrs _____

Cheque No: _____ Cheque Date: _____

Drawn on Bank for a sum of ₹ _____ towards payment of premium on behalf of HDFC ERGO General Insurance Company Ltd.

Date: _____ Signature & Seal: _____

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which 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 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.