



### 5. NOMINEE DETAILS

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.

Nominee Name	Relationship	Address of the Nominee

\*If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship	Address of Appointee

### 6. EXISTING/PREVIOUS INSURANCE DETAILS\*

Is the proposer or the persons proposed, already insured under a plan with HDFC ERGO General Insurance Company Limited or any other insurance company?  Yes  No  
If yes, please indicate below the Policy/ Application number(s) (Please mention application number incase of pending proposal.)

Since when are you continuously insured: 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Do you want Us to consider these details for continuity\*\*?  Yes  No

Policy No./Application No.	Insurer	Period of Insurance								Sum Insured (Rs.)	Claims lodged during the preceding 3 years				
		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		

\* Please note that continuity of benefits shall NOT be considered if the details are not provided.

### 7. MEDICAL AND LIFE STYLE INFORMATION

Medical History: Please answer the below mentioned questions Yes (Y) or No (N) ONLY:

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
i.	Hypertension, Chest Pain, Ischemic heart disease or any other cardiac disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
ii.	Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
iii.	Ulcer (stomach/duodenal), hepatitis, cirrhosis or any other Digestive or Liver/ Gallbladder disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
iv.	Renal failure, calculus or any other Kidney/Urinary tract or Prostate disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
v.	Dizziness, Stroke, Epilepsy, Paralysis or other brain/ nervous system disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
vi.	Diabetes, Thyroid disorder or any other endocrine disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
vii.	Tumor-benign or malignant, any ulcer/growth/cyst	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
viii.	Arthritis, Spondylosis or any other disorder of the muscle/bone/joint	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
ix.	Diseases of the Nose/Ear/Throat/Teeth/ Eye ( please mention Diopters )	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
x.	HIV/AIDS or sexually transmitted diseases or any immune system disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
xi.	Anaemia, Leukaemia or any other blood/lymphatic system disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
xii.	Psychiatric/Mental illnesses or Sleep disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
xiii.	DUB, Fibroid, Cyst/Fibroadenoma or any other Gynaecological/Breast disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Section B : Have any of the persons proposed to be insured:			
xiv.	Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
xv.	Been under any regular medication (self/ prescribed)?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
xvi.	Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
xvii.	Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
xviii.	Suffered from any other disease/illness/accident/injury other than common cold or fever?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
xix.	Is any of the insured persons pregnant? If yes, please mention the expected date of delivery _____	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
xx.	Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

# Optima Senior

## Proposal Form



Section C : Name and details of Illness/ Medicine/Test/Surgery/ Diopter grade (for questions answered as Yes in Section A & B above)	Diagnosis date	Date of last consultation	Treatment In/ Outpatient	Doctor/Hospital Name & Phone No.
Insured Person 1 :				
Insured Person 2 :				

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

Section E : Does any person proposed to be insured smoke or consume gutkha/ pan masala or alcohol. If yes, please indicate the name and quantity per week:	Alcohol	Smoke	Pan Masala	Others
Insured Person 1 :				
Insured Person 2 :		Y <input type="checkbox"/> N <input type="checkbox"/>		

Section F : In respect of any of the persons proposed to be insured:	Insured Person 1	Insured Person 2
Has any application for life, health, hospital daily cash or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

### 8. PAYMENT DETAILS

Instrument type : Cash  Cheque  Debit Card  Credit Card  Others \_\_\_\_\_

Instrument No.	Name of the Premium Payor	Bank Details	Date	Amount (in Rs.)

Please make a A/C Payee Cheque/DD/Pay Order in favour of 'HDFC ERGO General Insurance Company Limited' only.

Section 41 of Insurance Act 1938 as amended by Insurance Laws Amendment Act, 2015 (Prohibition of Rebates): 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. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to 10 lakh rupees.

### ADDITIONAL INFORMATION

(If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

### 9. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS 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, 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 anytime 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/We have understood the purpose of Aadhaar authentication and hereby state that I/We have no objection in providing my Aadhaar details.
- 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.

Date :

Time :

Place :

Signature of the Proposer :

### 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 :

Name of the witness :

Date :

Place :

Name of the witness :

### 10. AGENT'S DECLARATION

I, \_\_\_\_\_ (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 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.

License No. (Advisor/Corporate Agent/Broker/Relationship Officer) :

Date :

Place :

Signature of Agent :

### 11. CHECKLIST

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
4. Renewal Notice with claim details
5. Certification of previous insurer for previous claim details
6. Photocopies of all previous policies and endorsements

### 12. FOR OFFICE USE ONLY

HDFC ERGO General Insurance Company Limited	Office Code:	Advisors Code & Name :
Branch Receipt Date	:	Channel Type :
Business Type	: Urban/ Rural/ Social	

