

Critical Illness - Proposal Form

(All fields are mandatory and fill in CAPITALS only)

Application Number _____

Sourcing Channel / Agent / Broker Name

CP Code Sourcing Branch (City)

PROPOSER DETAILS

Proposer Mr. / Ms. / Mrs. (First Name) (Middle Name) (Last Name)

Address

City Pincode

State Sex Male Female

Tel.(Res.) (Off.) Mobile

E-mail

ID Proof Type PAN Passport Driving License Voters Card Others

PLAN DETAILS

Plan Name Silver

Proposed Policy Period to

DETAILS OF THE PERSON PROPOSED TO BE INSURED

S.No.	Name of the insured person	Relationship	Gender*	Date of Birth	Sum Insured
				<input type="text"/>	

*Gender Code M (Male), F (Female)

EXISTING/PREVIOUS INSURANCE DETAILS

(Including any with HDFC ERGO General Insurance Company Ltd.)

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

MEDICAL AND LIFE STYLE INFORMATION

Medical History: Please answer the below mentioned questions in Yes(Y) / No (N)

Section A: Have the insured ever suffered from/currently suffering from any of the following :

	Insured 1	Insured 1
1. Hypertension, Chest Pain, Ischemic heart disease or any other cardiac disorder		8. Arthritis, Spondylosis or any other disorder of the muscle / bone / joint
2. Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder		9. Diseases of the Nose / Ear / Throat / Dental / Eye (please mention dioptries)
3. Ulcer(Stomach/Duodenal), Hepatitis, Cirrhosis or any other digestive or liver / gallbladder disorder		10. HIV/AIDS or sexually transmitted diseases or any immune system disorder
4. Renal Failure, Calculus or any other kidney/urinary tract or prostate disorder		11. Anaemia, Leukaemia or any other blood/lymphatic system disorder
5. Dizziness, Stroke, Epilepsy, Paralysis or other brain/ nervous system disorder		12. Psychiatric / Mental illnesses or sleep disorder
6. Diabetes, Thyroid Disorder or any other endocrine disorder		13. DUB, Fibroid, Cyst / Fibroadenoma or any other Gynecological/Breast disorder (for female lives only)
7. Tumor-benign or malignant, any ulcer / growth / cyst		
Section B: Have any of the insured persons:		
14. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy		18. Suffered from any other disease / illness / accident / injury
15. Been under any Regular medication (self / prescribed)		19. Is any of the insured pregnant? If yes please mention the expected date of delivery
16. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years		20. Any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy
17. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending		

Section C: Name of Illness/Medicine/Test/Surgery/ diopter grade (for questions answered as Yes in Section A & B)	Diagnosis date	Date of Last Consultation	Treatment in / outpatient	Doctor/Hospital Name and Phone No.
Insured 1				

ACKNOWLEDGEMENT - CUSTOMER COPY

Please retain this counterfoil for your records

