# **HDFC ERGO General Insurance Company Limited**

# **Proposal Form**

# HDFC ERGO

Op	otima	Lite	<b>Plan</b>
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Application No. \_\_\_\_\_

Photograph
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- 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 C	Intermediary Code Intermediary									Intermediary Number									
	PROPOSER DETAILS																		
Name of the Proposer Date of Birth	D D M M Y	YYY								Nati	ional	lity			$\prod$		I		
Residential Status	Residen	t Indian			NRI				Cl										
Current Country of Res	idence 🔲												l						
Address																$\Box$	$\perp$		
	City									Dist	rict					$\Box$	$\perp$		
	State											Pi	n C	ode	<u> </u>	$\Box$	$\perp$		
Please tick if your pe	ermanent add	dress is s	same	as ab	ove.	If no	t, kin	ıdly fi	II the	e be	low:								
Permanent Address																$\square$			
	City									Dist	rict[				$\perp$	$\Box$			
	State											Pi	n C	ode	_] و	$\Box$			
E-Mail																			
GSTIN / UIN (if any)																			
Marital Status	Single	Ma	rried			Con	tact I	Numl	oer [										
Permanent Account Nu	mber (PAN)					]													
I have eIA	Yes	☐ No																	
I would like to apply for	elA 🗌 Ka	ırvy		CAMS	5		NSDI	L		CD	SL								
Annual Income	Upto 2.5	Lac		2.5 La	ic to	5 Lac	: [	_ 5 l	_ac t	o 15	Lac								
	☐ 15 Lac to	30 Lac		bove	30 I	Lac													
Education Level																			
Employee ID (Employee	es of HDFC G	Group an	d Mui	nich F	Re Gi	roup)							$\perp$	$\coprod$	$\Box$	$\perp$	Ш		
Policy Number of any a	ctive HDFC E	ERGO Po	licy w	here	you	are t	he P	olicyl	hold	er									
																$\Box$			
CKYC No.						]													
Are you a Politically Exp	oosed Persor	ı (PEP) o	r fami	ly me	embe	er/ clo	se re	elativ	e/a	ISSO	ciate	of	PEF	၁ [		Yes	5	_ \	۷o

Note: Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials.

Occu	Occupation  Salaried Self Employed Business Owner Retired Others If others, please select source of income whichever is applicable: Rentals Interest Pension Investment												
Industry Type  Antique dealer Art dealer  Import-Export Mining  Scrap Dealing Agriculture  BFSI Real Estate Manufacturing  if Others, please specify													
-	ur total aggregate p INR 2 lakhs? [	remium acros	ss all produ No	cts with HD	FC ERGO	General Insuranc	e Company	Limited more					
-	ou have investable a oonds etc.)	assets for mo	re than INR No	5 crores? (	Investable	assets like cash l	noldings, de	posits, stocks					
-	ur total aggregate p 10 lakhs or more? [	remium acros	ss all retail <sub> </sub>	products wi	ith HDFC E	RGO General Ins	urance Con	npany Limited					
		DETAILS O	F THE PER	SON(S) PR	OPOSED T	O 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													
	: In case any insured ://healthid.ndhm.go		ish to gene	rate his/he	r ABHA ID.	Kindly visit the lir	ık:						
			PREMI	UM TIER (F	Please Tick								
	Т	ier 1 🗌				Tier 2							
	sification of Cities fo			Mumbai	Mumbai Su	iburban Thano	and Navi M	lumbai Surat					

- 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.

HDFC ERGO General Insurance Company Limited. IRDAI Reg. No.146 CIN: U66030MH2007PLC177117. Registered & Corporate Office: 6th Floor, Leela Business Park, Andheri-Kurla Road, Andheri (East), Mumbai – 400 059. Customer Experience Management, Customer Happiness Center: D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai - 400 078. For Claim/Policy related queries call us at 022 6158 2020 / 022 6234 6234 or Visit Help Section on www.hdfcergo.com for policy copy/tax certificate/make changes/register & track claim. Product Name: my: Optima Secure | Product UIN: HDFHLIP25041V062425 | Product Code - HE/RL/Health/24-25/2611 ABCD Chronic Care - HDFHLIA25044V012425 | Parenthood - HDFHLIA25046V012425 my: health Critical Illness - HDFHLIA22141V032122 | my:Health Hospital Cash Benefit (Add-on) - HDFHLIA21271V022021 | IPA Rider – APOPAIP19004V011920 | Optima Wellbeing (Add-on) - HDFHLIA24099V012324.

Name of Person Proposed to be insured	Name of Nominee	Relationship	Address of the Nominee	Permanent Address of Nominee (If same not required to be filled)	e-mail of Nominee	Mobile number of Nominee	Bank account number of Nominee	IFSC Code	Name of the Bank	% Share of Nomination												
Where Nominee is a minor, please give the details of Appointee  Name of the Appointee Relationship to Nominee Address of the Appointee																						
Name of the Appointee Relationship to Nominee Address of the Appointee																						
Note: 1. The n	ominee m	iust be an ir	nmediate i	relative of t	the Propos	ser. Nomin	ee for anv	of the per	sons prop	osed to be												
insure	ed shall be	the Propos	ser.		·		-	·														
2. Name	e of Nomin	iee should l	oe as per b	ank record	ds to ensu	re smooth	processin	g														
				POI	LICY DETA	AILS																
Policy T	ype	Individu	al 🗌	Family	y Floater [																	
Tenure		1 Year	2 Year	3 Ye	ar 🗌																	
Policy P	eriod	From D	D M M Y	YYY	O D D M N	И У У У	]															
				SUM	INSLIDE	) in ₹																
	SUM INSURED in ₹																					

**NOMINEE DETAILS** 

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PTI			

S. No	o. Optional	Cover						Desc	ripti	on / C	Optio	ns						
1	Protect Benefit					Yes												
2	PED waiting period mod (allowed to be opted at		only	/)	]:	36 months (default) 24 months 12 months												
3	Plus Benefit				ш I	Bonus of 50% of the Base Sum Insured, maximum upto 100%												
4	Aggregate Deductible					<pre></pre>												
			AD	D-C	ON C	OVERS												
						0 0 2.1.0												
1	my: health Critical Illness(You can opt for a Sum Insured from 1 Lakh to 500 Lakhs)			_	(9 II	Plan 1 Inesses	s)	Plan (12 Illnesse		(15 II	Plan Iness		(18 II	Plan Iness				
					(25 I	Plan 5 Illnesse		Plan (40 IIIness			Plar	า 7 (5	51 IIIn	esses	\$)			
2	Individual Personal Accid	ent (IPA) Rider							Yes									
3 (a)	my:health Hospital Cash	Benefit				Yes												
3 (b)	Hospital Cash benefit – G cover)	Global (Optiona	al [						Ye	⁄es								
4	Optima Wellbeing (Add o	n)							Ye	S								
5	Parenthood		[		₹ 50	K		₹ 100K		₹ 150	K		₹ 20	OK				
S. No.	Name	IPA Rider Sum Insured in ₹	ABCD Chron opted kindly ti		dly tic	k below)		my: health critical Illness Sum Insured in ₹	my		ed Per		Sum In:		um 10			
1									0.5	'		3	3	7.5	10			
2															-			
3																		
4															=			
5															-			
					ш				ļ	1								

## Notes pertaining to Add-on covers

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- a. Coverage for 'my:health Critical Illness' shall be on Individual Sum Insured basis only.
- b. 'my: health Critical Illness' can be opted by adults (persons over 18 years of age) only
- c. 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 ₹1 Crore and this rider will be offered only to the Proposer when he/she is covered in the Base plan.
- d. 'Parenthood' can be opted if at least 1 female of 18 year or above is insured under the Base plan.

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# **NRI DISCOUNT AND OTHER ITEMS**

Yes

**NRI** Discount

policy are NRIs)

<ul><li>a. For continuity NRIs and resi</li><li>b. If at renewal</li></ul>	ding overseas.	t, at each renewa	-				
Other Items		o our planet! We	shall provide y	ou with soft c	opy of your P	olicy at you	r registerec
claims and for ar $\Box$ Additionally, b	ny other service r by ticking the che ne process to rec	eck box we under ceive your physic	rstand that you	wish to have	e a physical c	opy of your	policy.
	EXI:	STING/PREVIOU	S INSURANCE	E POLICY DE	TAILS		
from HDFC ERG		insured presentl nsurer?	iy nola any mea	aith insuranc	e/Critical IIIn	ess insuran	ice Policies
Policy No. / Application No.	_		DD/MM/	Insurance YYYY To M/YYYY	Sum Insured	Claims lodged during the preceding	To be considered for continuity
Policy No. /	ovide below deta	Name of the	DD/MM/	YYYY To		lodged during the	considered for
Policy No. /	ovide below deta	Name of the	DD/MM/	YYYY To		lodged during the preceding years	considered for continuity
Policy No. /	ovide below deta	Name of the	DD/MM/	YYYY To		lodged during the preceding years	considered for continuity

1. Do you want to avail NRI Discount? (This option is available only if all proposed insured person(s) under the

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:

	$oxedsymbol{oxed}$ I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that I/We do not holo
ar	ny 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**

Pl€	ease select Medical Question for <name be="" insured="" of="" person="" proposed="" the="" to=""></name>	
1.	Has an ailment or disability or deformity including due to accident or congenital disease	
	Has planned a surgery	☐ Yes ☐ No
	Takes medicines regularly	☐ Yes ☐ No
	Has been advised investigation or further tests	☐ Yes ☐ No
	Was hospitalized in the past Is Pregnant	☐ Yes ☐ No☐ Yes ☐ No
0.	-	res no
7	(Applicable for females >=18 years and <=55 years.)  Are you having any disability/ deformity including accidental or congenital?	☐ Yes ☐ No
	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 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 Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders	pelow details
	<ul> <li>Eye or vision disorders/ Ear/ Nose or Throat diseases</li> <li>Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligame</li> <li>Any other disease/condition not mentioned above</li> </ul>	nt/ Cartilage
	(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood	l pressure
	Exact Diagnosis:	
	Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids	
	Are you taking Anti-Hypertensive Drugs? $\square$ Yes $\square$ No (If answer is 'No', below	
	Question: Have you stopped medication on Doctor's advice?	Yes No
	Diagnosis Date:	
	Hospital Name:	
	Consultation Date:	
	(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood su	gar / Sugar in urine
	Exact Diagnosis: Type 1 DM / IDDM Type 2 DM Gobb (Gestational D	iabetes)
	Are you taking insulin?	Yes No
	Diagnosis Date:	
	Hospital Name:	
	Consultation Date	

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	(iii)	Please share details for your ailment (except for Diabetes and Hypertension)
		Exact Diagnosis:
		Diagnosis Date:
		Treatment type:
		Complications / Recurrence:
		Current status: Pending Treatment Ongoing Treatment Cured  If others, please specify
		Biopsy report: Malignant Non-Malignant Not Applicable
		Consultation Date:
		Hospital Name:
		Please share details of your treatment:
2.	Has	s planned a surgery Yes No. If Yes, please provide the below details
		ease share details of surgery <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
		act Diagnosis:
		agnosis Date:
		nsultation Date:
		spital Name:
		posed Surgery:
		rase share details of your past surgery <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
		ase share detaile of your past sargery maine of the person proposed to so insured
3.		res medicines regularly Yes No. If Yes, please provide the below details rease share details for your current medication <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
	(i)	If exact diagnosis is Hypertension then please provide details of the below questions
		Exact Diagnosis:
		Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? U Yes U No
		Diagnosis Date:
		Consultation Date:
	(ii)	If exact diagnosis is Diabetes then please provide details of the below questions
		Exact Diagnosis:
		Takes insulin Yes No
		Diagnosis Date:
		Consultation Date:
	(iii)	If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:
		Exact Diagnosis:
		Diagnosis Date:
		Consultation Date:
		Medicine Name:
		Please share details of your treatment <name be="" insured="" of="" person="" proposed="" the="" to=""></name>

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	Please provide de insured> Date of tests: Type of tests: Findings of tests: _ Please upload the Was hospitalized in	investigation ten past Yes	stigation suggested	by your Doctor <nam< th=""><th>please provide the belone of the person propositions of the person propositions of the person propositions of the person proposed to be insured.</th><th>sed to be</th></nam<>	please provide the belone of the person propositions of the person propositions of the person propositions of the person proposed to be insured.	sed to be						
	Hospital Name: Please share detai		modical condition									
	Flease strate detail	iis oi youi past i	nedical condition									
6.	Is Pregnant $\square$ Y	∕es □ No	If Yes, please prov	ide the below details								
	Please share your	expected delive	ery date with us									
	7. Are you having any disability/ deformity including accidental or congenital?											
		-	SECTION TO BE FII	-								
		-		r Horizon or both ad								
	• , ,	-			since past	-						
					since past							
		-			since past	•						
		-			since past	_						
		-			since past since past	_						
	Drugs_(Quaritity)	rei Day	Per Week	Per Month	Since past	years						
		ME	DICAL AND LIFES	TVI E INICODMATION								
	(Please provide i			TYLE INFORMATION nentioned under Pro	posed Persons to be in	sured)						
INS Ple 1.	EDICAL & LIFESTYLED BE REPEATED FO SURED - 2 Pase select Medical Has an ailment or	LE QUESTIONS OR EACH PERS Question for <n def<="" disability="" or="" td=""><td>FOR PERSON PROON PROPOSED TO ame of the person pormity including due</td><td>DPOSED TO BE INSU BE INSURED] proposed to be insure to accident or cong</td><td><b>RED</b></td><td>s 🗌 No</td></n>	FOR PERSON PROON PROPOSED TO ame of the person pormity including due	DPOSED TO BE INSU BE INSURED] proposed to be insure to accident or cong	<b>RED</b>	s 🗌 No						

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	Has planned a surgery Takes medicines regularly	Yes No
	Has been advised investigation or further tests	Yes No
	Was hospitalized in the past	☐ Yes ☐ No
	Is Pregnant	Yes No
	(Applicable for females >=18 years and <=55 years.)	
7.	Are you having any disability/ deformity including accidental or congenital?	Yes No
ΔC	DDITIONAL MEDICAL QUESTIONS	
RE	ELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]	
١.	Has an ailment or disability or deformity	ow 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	
	<ul><li>Ulcer (Stomach/ Duodenal), or any ailment of Digestive System</li><li>Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic di</li></ul>	cordor
	HIV Infection/AIDS or Positive test for HIV	sorder
	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	
	(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pr	essure
	Exact Diagnosis:  Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids?	Yes No
	Are you taking Anti-Hypertensive Drugs? $\square$ Yes $\square$ No (If answer is 'No', below qu	
	· · · · · · · · · · · · · · · · · · ·	Yes No
	Question: Have you stopped medication on Doctor's advice?	163 140
	Diagnosis Date:	
	Hospital Name:	
	Consultation Date:	
	(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar	· ·
	Exact Diagnosis: U Type 1 DM / IDDM U Type 2 DM U GDM (Gestational Diab	_ · _
	Are you taking insulin?	Yes No
	Diagnosis Date:	
	Hospital Name:	
	Consultation Date	
	(iii) Please share details for your ailment (except for Diabetes and Hypertension)	
	Exact Diagnosis:	
	Diagnosis Date:	
	Treatment type: $\square$ Medical $\square$ Surgical	
	Complications / Recurrence: $\square$ Yes $\square$ No	
	Current status: $\square$ Pending Treatment $\square$ Ongoing Treatment $\square$ Cured	

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	$\square$ If others, please specify
	Biopsy report: Malignant Non-Malignant Not Applicable
	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=""></name>
	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>
3.	Takes medicines regularly
	Please share details for your current medication <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
	Theade Share details for your current medication. Hame or the percent proposed to se medicat
	(i) If exact diagnosis is Hypertension then please provide details of the below questions
	Exact Diagnosis:
	Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? $\Box$ Yes $\Box$ No
	Diagnosis Date:
	Consultation Date:
	(ii) If exact diagnosis is Diabetes then please provide details of the below questions
	Exact Diagnosis:
	Takes insulin
	Diagnosis Date:
	Consultation Date:
	(iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:
	Exact Diagnosis:
	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 $\square$ Yes $\square$ No. If Yes, please provide the below details
	Please provide details about investigation suggested by your Doctor <name be<="" of="" person="" proposed="" td="" the="" to=""></name>
	insured>
	Date of tests:
	Type of tests:
	Findings of tests:
	Please upload the investigation tests results

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5.	Was hospitalized in	n past 🔲 Yes	☐ No If Yes, ple	ease provide the belo	ow details	
	Please share detai	ils for your past me	edical condition <nan< th=""><th>ne of the person pro</th><th>posed to be insured&gt;</th><th></th></nan<>	ne of the person pro	posed to be insured>	
	Exact Diagnosis: _					
	Diagnosis Date:					
	Consultation Date:					
	Hospital Name:					
	Please share detai					
		, , , , , , , , , , , , , , , , , , , ,				
6.	Is Pregnant \( \sum \) \( \text{Y} \)		Yes, please provide	the below details		
	Please share your	expected delivery	date with us			
7.	Are you having any	y disability/ deform	nity including accider	ntal or congenital?	☐ Yes ☐ No	
		he specific boxes t	hat are applicable:			
	☐ Amputation					
	☐ Musculoskeleta					
	<ul><li>☐ Neurological / Polio</li></ul>	Cerebral Palsy				
	Spinal cord					
	Stroke					
	☐ Visual / Hearing	g disability				
	Others					
	Kindly provide a de	etailed description	for all boxes ticked	above:		
LIF	ESTYLE QUESTION	<b>NS</b> [RELEVANT SE	CTION TO BE FILLED	<b>)</b> ]		
[TC	BE FILLED ONLY	IF my: health Criti	ical Illness or Her Ho	orizon or both add-o	n/s is /are opted]	
	Cigarette(s)	Per Day	_ Per Week	_ Per Month	since past	_ years
	Bidi(s)	Per Day	_ Per Week	_ Per Month	since past	_ years
	Tobacco Pouches	Per Day	_ Per Week	_ Per Month	since past	_ years
	Gutka Pouches	Per Day	_ Per Week	_ Per Month	since past	_ years
	Alcohol (Quantity)	Per Day	_ Per Week	_ Per Month	since past	_ years
	Drugs_(Quantity)	Per Day	_ Per Week	_ Per Month	since past	_ years
		MEDI	CAL AND LIFESTYL	E INFORMATION		
	(Please provide i	nformation in the	same order as ment	tioned under Propos	sed Persons to be insu	red)
ME	DICAL & LIFESTYL	LE QUESTIONS FO	OR PERSON PROPO	SED TO BE INSURE	D	
[TC	BE REPEATED FO	OR EACH PERSON	I PROPOSED TO BE	INSURED]		
INS	SURED - 3					
			e of the person prop			□ Na
1.		•	nity including due to	accident or congeni	tal disease 🔲 Yes   	∐ No □ No
	Has planned a sure Takes medicines re				☐ Yes	☐ No
	Has been advised	= -	rther tests		Yes	☐ No
	Was hospitalized in	-			Yes	☐ No
6.	Is Pregnant				Yes	☐ No
	(Applicable for fem	-	- '			<b>.</b> .
7.	Are you having any	y disability/ deform	nity including accider	ntal or congenital?	Yes	∐ No

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#### ADDITIONAL MEDICAL QUESTIONS

[RELE	VANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]
	as an ailment or disability or deformity 🔲 Yes 🗌 No If Yes, please provide the below details
PI	ease tick additional information about your ailment for
H	Hypertension/ High blood pressure Diabetes/ High blood sugar/Sugar in urine
H	Cancer, Tumour, Growth or Cyst of any kind
F	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
L	Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
	Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders
H	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
(i)	Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure
	Exact Diagnosis:
	Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? 🗌 Yes 🔲 No
	Are you taking Anti-Hypertensive Drugs? $\square$ Yes $\square$ No (If answer is 'No', below question is mandatory)
	Question: Have you stopped medication on Doctor's advice?  Yes No
	Diagnosis Date:
	Hospital Name:
	·
	Consultation Date:
(ii)	
	Exact Diagnosis: Type 1 DM / IDDM Type 2 DM GDM (Gestational Diabetes)
	Are you taking insulin?
	Diagnosis Date:
	Hospital Name:
	Consultation Date
(iii	) Please share details for your ailment (except for Diabetes and Hypertension)
	Exact Diagnosis:
	Diagnosis Date:
	Treatment type:  Medical  Surgical
	Complications / Recurrence:
	Current status: $\square$ Pending Treatment $\square$ Ongoing Treatment $\square$ Cured
	If others, please specify
	Biopsy report: Malignant Non-Malignant Not Applicable
	Consultation Date:
	Hospital Name:
	Please share details of your treatment:
	·

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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=""></name>							
	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>							
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=""></name>							
	(i) If exact diagnosis is Hypertension then please provide details of the below questions							
	Exact Diagnosis:							
	Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids?							
	Diagnosis Date:							
	Consultation Date:							
	(ii) If exact diagnosis is Diabetes then please provide details of the below questions							
	Exact Diagnosis:							
	Takes insulin							
	Diagnosis Date:							
	Consultation Date:							
	(iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions							
	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 $\square$ 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=""></name>							
	Date of tests:							
	Type of tests:							
	Findings of tests:							
	Please upload the investigation tests results							
5.	Was hospitalized in past $\ \square$ Yes $\ \square$ No $\ $ If Yes, please provide the below details							
	Please share details for your past medical condition <name be="" insured="" of="" person="" proposed="" the="" to=""></name>							
	Exact Diagnosis:							
	Diagnosis Date:							
	Consultation Date:							
	Hospital Name:							
	Please share details of your past medical condition							

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	Is Pregnant $\; \bigsqcup \; Y$	′es ∟ No	If Yes, please prov	ide the below details		
	Please share your	expected delive	ery date with us			
	If Yes, Kindly tick the Amputation Musculoskeleta Neurological / Polio Spinal cord Stroke Visual / Hearing Others	he specific boxe al / Locomotor Cerebral Palsy g disability	es that are applicabl		Yes No	
LIF	ESTYLE QUESTIO	<b>NS</b> [RELEVANT	SECTION TO BE FII	_LED]		
		-		r Horizon or both add	d-on/s is /are opted]	
	Cigarette(s)	Per Day	Per Week	Per Month	since past	years
	Bidi(s)	Per Day	Per Week	Per Month	since past	years
	Tobacco Pouches	Per Day	Per Week	Per Month	since past	years
	Gutka Pouches	Per Day	Per Week	Per Month	since past	years
	Alcohol (Quantity)	Per Day	Per Week	Per Month	since past	years
	Drugs_(Quantity)	Per Day	Per Week	Per Month	since past	years
		ME	DICAL AND LIFES	TYLE INFORMATION		
	(Please provide i				posed Persons to be in	sured)
	DICAL & LIFESTYL	nformation in t LE QUESTIONS	he same order as n FOR PERSON PRO	nentioned under Prop PPOSED TO BE INSU	posed Persons to be in	sured)
[TO	DICAL & LIFESTYL	nformation in t LE QUESTIONS	he same order as n	nentioned under Prop PPOSED TO BE INSU	posed Persons to be in	isured)
[TO INS	DICAL & LIFESTYL BE REPEATED FO GURED - 4 ase select Medical	nformation in to LE QUESTIONS OR EACH PERSO Question for <n< td=""><td>he same order as n FOR PERSON PRO ON PROPOSED TO ame of the person p</td><td>proposed to be insure</td><td>posed Persons to be in</td><td></td></n<>	he same order as n FOR PERSON PRO ON PROPOSED TO ame of the person p	proposed to be insure	posed Persons to be in	
[ <b>TO</b> <b>INS</b> Plea 1.	DICAL & LIFESTYL BE REPEATED FO GURED - 4 ase select Medical Has an ailment or	nformation in to LE QUESTIONS OR EACH PERSO Question for < no disability or defo	he same order as n FOR PERSON PRO ON PROPOSED TO ame of the person p	nentioned under Prop PPOSED TO BE INSU BE INSURED]	posed Persons to be in RED  ed> enital disease  Yes	s 🔲 No
[TO INS Plea 1. 2.	DICAL & LIFESTYLE  BE REPEATED FOURED - 4  ase select Medical  Has an ailment or  Has planned a sur	nformation in to LE QUESTIONS OR EACH PERSO Question for <no disability or defo gery</no 	he same order as n FOR PERSON PRO ON PROPOSED TO ame of the person p	proposed to be insure	posed Persons to be in RED  ed> enital disease Yes	s No
[ <b>TO</b> INS Plead 1. 2. 3.	DICAL & LIFESTYL BE REPEATED FO GURED - 4 ase select Medical Has an ailment or	nformation in to LE QUESTIONS OR EACH PERSON Question for < no disability or deformation gery egularly	he same order as no FOR PERSON PROON PROPOSED TO ame of the person pormity including due	proposed to be insure	posed Persons to be in RED  ed> enital disease  Yes	S No S No S No
[ <b>TO</b> INS Plead 1. 2. 3. 4.	DICAL & LIFESTYLE  BE REPEATED FOR  GURED - 4  ase select Medical  Has an ailment or a sure  Takes medicines re	nformation in to LE QUESTIONS OR EACH PERSON Question for a disability or deformation or a gery egularly investigation or a second control of the control of	he same order as no FOR PERSON PROON PROPOSED TO ame of the person pormity including due	proposed to be insure	ed> enital disease Yes	s
[TO INS Pleat 1. 2. 3. 4. 5. 6.	DICAL & LIFESTYLE BE REPEATED FOR SURED - 4 ase select Medical Has an ailment or Has planned a sure Takes medicines re Has been advised Was hospitalized in Is Pregnant	nformation in to LE QUESTIONS OR EACH PERSO Question for <no disability or defo gery egularly investigation or n the past</no 	he same order as no FOR PERSON PRO ON PROPOSED TO ame of the person pormity including due or further tests	proposed to be insure	ed> enital disease Yes Yes	S No S No S No S No S No
[TO INS Pleat 1. 2. 3. 4. 5. 6.	DICAL & LIFESTYLE BE REPEATED FOR BURED - 4 ase select Medical Has an ailment or Has planned a sur Takes medicines re Has been advised Was hospitalized in Is Pregnant (Applicable for fem	nformation in to LE QUESTIONS OR EACH PERSON Question for < nd disability or defended gery egularly investigation or not the past	he same order as not provided the same of the person pormity including due or further tests	pentioned under Proposed TO BE INSULATION (INSURED)  proposed to be insured to accident or conge	ed> enital disease	S No S No S No S No S No S No
ITO INS Pleat. 1. 2. 3. 4. 5. 6.	DICAL & LIFESTYLE BE REPEATED FOR BURED - 4 ase select Medical Has an ailment or Has planned a sur Takes medicines re Has been advised Was hospitalized in Is Pregnant (Applicable for fem	nformation in to LE QUESTIONS OR EACH PERSO Question for <no defo="" disability="" egularly="" gery="" investigation="" n="" nales="" or="" past="" the="">=18 years y disability/ defo</no>	he same order as not provided the same of the person pormity including due or further tests and <=55 years.)  by printing including according to the same of the person pormity including due or further tests	proposed to be insure	ed> enital disease	S No S No S No S No S No S No

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<ul> <li>Ulcer (Stomach/ Duodenal), or any ailment of Digestive System</li> <li>Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder</li> <li>HIV Infection/AIDS or Positive test for HIV</li> <li>Nervous, Psychiatric or Mental or Sleep disorder</li> <li>Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)</li> <li>Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders</li> <li>Eye or vision disorders/ Ear/ Nose or Throat diseases</li> <li>Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage</li> <li>Any other disease/condition not mentioned above</li> </ul>
(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure
Exact Diagnosis:
Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids?
Are you taking Anti-Hypertensive Drugs? $\square$ Yes $\square$ No (If answer is 'No', below question is mandatory)
Question: Have you stopped medication on Doctor's advice?
Diagnosis Date:
Hospital Name:
Consultation Date:
(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine
Exact Diagnosis: Type 1 DM / IDDM Type 2 DM Gestational Diabetes)
Are you taking insulin?
Diagnosis Date:
Hospital Name:
Consultation Date
(iii) Please share details for your ailment (except for Diabetes and Hypertension)
Exact Diagnosis:
Diagnosis Date:
Treatment type: $\square$ Medical $\square$ Surgical
Complications / Recurrence: $\square$ Yes $\square$ No
Current status: $\square$ Pending Treatment $\square$ Ongoing Treatment $\square$ Cured $\square$ If others, please specify
Biopsy report: Malignant Non-Malignant Not Applicable
Consultation Date:
Hospital Name:
Please share details of your treatment:
Has planned a surgery $\square$ Yes $\square$ No. If Yes, please provide the below details
Please share details of surgery <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
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>

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2.

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=""></name>					
	(i)	If exact diagnosis is Hypertension then please provide details of the below questions  Exact Diagnosis:  Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids?   Yes No  Diagnosis Date:				
		Consultation Date:				
	(ii)	If exact diagnosis is Diabetes then please provide details of the below questions  Exact Diagnosis:				
		Takes insulin				
	(iii)	Consultation Date:  If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions: Exact Diagnosis:				
		Diagnosis Date:				
		Consultation Date:				
		Medicine Name:				
		Please share details of your treatment <name be="" insured="" of="" person="" proposed="" the="" to=""></name>				
4.	Ple ins Da Typ Fin	s been advised investigation or further tests				
<b>E</b>		ase upload the investigation tests results s hospitalized in past Session Tests Solon If Yes, please provide the below details				
5.	Ple Exa Dia Co	ease share details for your past medical condition <name be="" insured="" of="" person="" proposed="" the="" to=""> act Diagnosis: agnosis Date: nsultation Date: spital Name:</name>				
	Ple	ase share details of your past medical condition				
6.		Pregnant				
7.		e you having any disability/ deformity including accidental or congenital? Yes No Yes, Kindly tick the specific boxes that are applicable: Amputation Musculoskeletal / Locomotor Neurological / Cerebral Palsy Polio				

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	☐ Spinal cord						
	Stroke						
	☐ Visual / Hearing disability						
	Others						
	Kindly provide a de	etailed description	for all boxes ticked	above:		-	
LIF	ESTYLE QUESTION	<b>NS</b> [RELEVANT SE	CTION TO BE FILLE	D]			
[TC	D BE FILLED ONLY	IF my: health Crit	ical Illness or Her H	orizon or both add-	on/s is /are opted]		
	Cigarette(s)	Per Day	_ Per Week	Per Month	since past	years	
	Bidi(s)	Per Day	_ Per Week	_ Per Month	since past	years	
	Tobacco Pouches	Per Day	_ Per Week	Per Month	since past	years	
	Gutka Pouches	Per Day	_ Per Week	Per Month	since past	years	
		-			since past	-	
	, , , , , , , , , , , , , , , , , , , ,	•			since past	•	
	3 – ( ),	,				_,	
		MEDI	CAL AND LIFESTYL	E INFORMATION			
	(Please provide i				sed Persons to be ins	ured)	
MF				SED TO BE INSURE		·	
			I PROPOSED TO BE		.0		
-	SURED - 5						
Ple	ease select Medical	Question for <nam< th=""><th>e of the person prop</th><th>oosed to be insured</th><th>&gt;</th><th></th></nam<>	e of the person prop	oosed to be insured	>		
1.	Has an ailment or	disability or deform	nity including due to	accident or congen	ital disease	No	
	Has planned a sur	0 ,			☐ Yes	∐ No	
	Takes medicines re	•			∐ Yes	∐ No	
	Has been advised	•	irther tests		∐ Yes	∐ No	
	Was hospitalized in	n the past			☐ Yes	∐ No	
0.	Is Pregnant		ad <=FF \\alpha ara\		∐ Yes	∐ No	
7	(Applicable for fem	•	nity including accide	ntal or congenital?	Yes	No	
			mry meraamig acerae	intar or congenitar.			
	DOITIONAL MEDICA		NAMENI ANGWEDER	YES IN PREVIOUS	OLIESTIONII		
1.					vide the below details		
١.		-	out your ailment for	,  -			
		High blood pressu					
	Diabetes/ High	n blood sugar/Suga	ar in urine				
	Cancer, Tumou	ır, Growth or Cyst o	of any kind				
		•	other Heart Disease/				
			ndice/Hepatitis B or	С			
	= '		productive organs				
		Asthma or any other	•	. Constant			
	= '	·	y ailment of Digestiv	•	v ganatic dicardar		
	$=$ $\cdot$	AIDS or Positive tes	·	Thalassaemia) or ar	iy geneac disoldel		
		hiatric or Mental or					
	=		•	s disorder (Brain/ Spi	inal Cord etc.)		
			er or any Endocrine				
			e or Throat diseases	-			
	= '				t/ Ligament/ Cartilage		
	Any other disease/condition not mentioned above						

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(i)	Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure
	Exact Diagnosis:
	Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? U Yes U No
	Are you taking Anti-Hypertensive Drugs? $\square$ Yes $\square$ No (If answer is 'No', below question is mandatory)
	Question: Have you stopped medication on Doctor's advice?
	Diagnosis Date:
	Hospital Name:
	Consultation Date:
(ii)	Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine
	Exact Diagnosis: Type 1 DM / IDDM Type 2 DM Gestational Diabetes)
	Are you taking insulin?
	Diagnosis Date:
	Hospital Name:
	Consultation Date
(iii)	Please share details for your ailment (except for Diabetes and Hypertension)
	Exact Diagnosis:
	Diagnosis Date:
	Treatment type:  Medical Surgical
	Complications / Recurrence:
	Current status: Pending Treatment Ongoing Treatment Cured
	☐ If others, please specify
	Biopsy report: Malignant Non-Malignant Not Applicable
	Consultation Date:
	Hospital Name:
	Please share details of your treatment:
Ha	s planned a surgery 🗌 Yes 🔲 No. If Yes, please provide the below details
PΙε	ease share details of surgery <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
Ex	act Diagnosis:
Dia	agnosis Date:
Сс	onsultation Date:
Ho	ospital Name:
Pro	oposed Surgery:
Ple	ease share details of your past surgery <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
 Ta	kes medicines regularly Yes No. If Yes, please provide the below details
	ease share details for your current medication <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
	ease share details for your current medication \name of the person proposed to be insured.
(i)	If exact diagnosis is Hypertension then please provide details of the below questions
	Exact Diagnosis:
	Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? U Yes U No
	Diagnosis Date:
	Consultation Date:

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	(ii) If exact diagnosis is Diabetes then please provide details of the below questions					
	Exact Diagnosis:  Takes insulin  Yes  No					
	Diagnosis Date:					
	Consultation Date:					
	(iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:					
	Exact Diagnosis:					
	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 $\square$ Yes $\square$ No. If Yes, please provide the below details					
	Please provide details about investigation suggested by your Doctor <name be<="" of="" person="" proposed="" th="" the="" to=""></name>					
	insured>					
	Date of tests:					
	Type of tests:					
	Findings of tests:					
	Please upload the investigation tests results					
5.	Was hospitalized in past $\square$ Yes $\square$ No $\square$ If Yes, please provide the below details					
	Please share details for your past medical condition <name be="" insured="" of="" person="" proposed="" the="" to=""></name>					
	Exact Diagnosis:					
	Diagnosis Date:					
	Consultation Date:					
	Hospital Name:					
	Please share details of your past medical condition					
_						
6.						
_	Please share your expected delivery date with us					
7.						
	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 provide a detailed description for all boxes ticked above:					

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LIF	<b>ESTYLE QUESTIO</b>	NS [RELEVANT	SECTION TO BE FII	LLED]			
[TC	BE FILLED ONLY	IF my: health C	ritical Illness or He	r Horizon or both ad	d-on/s is /are opted]		
	Cigarette(s)	Per Day	Per Week	Per Month	since past	years	
	Bidi(s)	Per Day	Per Week	Per Month	since past	years	
	Tobacco Pouches	Per Day	Per Week	Per Month	since past	years	
	Gutka Pouches	Per Day	Per Week	Per Month	since past	years	
	Alcohol (Quantity)	Per Day	Per Week	Per Month	since past	years	
		_			since past	_	
	3 – ( ),	,				,	
		ME	EDICAL AND LIEES	TYLE INFORMATION			
	(Please provide i				posed Persons to be	insured)	
NAC	•			POSED TO BE INSU		,	
			ON PROPOSED TO		יאבט		
-	SURED - 6	OK LACITI EKS	OIVI KOI OSED IO	DE INSORED]			
Ple	ase select Medical	I Question for <n< td=""><td>ame of the person (</td><td>proposed to be insure</td><td>ed&gt;</td><td></td></n<>	ame of the person (	proposed to be insure	ed>		
			·	e to accident or cong		es 🗌 No	
	Has planned a sur	0 ,				es No	
	Takes medicines r	0 ,	6 .1			es No	
	Has been advised	•	r further tests			'es ∐ No	
	Was hospitalized i Is Pregnant	iii tile past				′es	
0.	(Applicable for fen	nales >=18 vears	and <=55 years )		·		
7.		•	•	cidental or congenital	? \( \sum_ \text{Y}	es No	
					_	_	
	DITIONAL MEDIC			RED YES IN PREVIOL	IS OLIESTIONI		
[N∟ 1	Has an ailment or	disability or def	ormity Yes	No If Yes, please p	provide the below deta	ails	
••	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						
	= -	n blood sugar/Sı	•				
		ur, Growth or Cy	•	<b>(5.1.</b> )			
			y other Heart Disea				
			aundice/Hepatitis B Reproductive organ				
	_ '		ther Lung disorder	13			
	=	-	any ailment of Dige	estive System			
			-		any genetic disorder		
	HIV Infection/A	AIDS or Positive	test for HIV				
	= -		l or Sleep disorder				
			•	ous disorder (Brain/ S	Spinal Cord etc.)		
				ine organ disorders			
			ose or Throat disea		oint/Ligamont/Cartilag	70	
	☐ Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage ☐ Any other disease/condition not mentioned above						
	i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure						
	Exact Diagnos	_			g =.000 procodic		
	_		ats/anti-coaqulants/l	Blood thinning agents	s/Δnti Linids? Yes	□No	
					'No', below question i	_	
	-		nedication on Docto		Yes		
	Question: Hav	e vou stopped f	nearanon on Docia	n a gavice:	103	1 110	

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Question: Have you stopped medication on Doctor's advice?

	Diagnosis Date:
	Hospital Name:
	Consultation Date:
(ii)	Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine
	Exact Diagnosis: Type 1 DM / IDDM Type 2 DM Gobble Gold (Gestational Diabetes)
	Are you taking insulin?
	Diagnosis Date:
	Hospital Name:
	Consultation Date
(iii)	Please share details for your ailment (except for Diabetes and Hypertension)
	Exact Diagnosis:
	Diagnosis Date:
	Treatment type:  Medical  Surgical
	Complications / Recurrence:
	Current status: Pending Treatment Ongoing Treatment Cured
	☐ If others, please specify
	Biopsy report: Malignant Non-Malignant Not Applicable
	Consultation Date:
	Hospital Name:
	Please share details of your treatment:
	,
Ha	s planned a surgery 🔲 Yes 🔲 No. If Yes, please provide the below details
Ple	ease share details of surgery <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
Exa	act Diagnosis:
Dia	agnosis Date:
Со	nsultation Date:
Но	ospital Name:
	pposed Surgery:
	ease share details of your past surgery <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
Tal	kes medicines regularly Yes No. If Yes, please provide the below details
	ease share details for your current medication <name be="" insured="" of="" person="" proposed="" the="" to=""></name>
1 10	state details for your current medication shalle of the person proposed to be insured
(i)	If exact diagnosis is Hypertension then please provide details of the below questions
(1)	Exact Diagnosis:
	Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids?  \Begin{array}{ c c c c c c c c c c c c c c c c c c c
	Diagnosis Date:
/···\	Consultation Date:
(ii)	
	Exact Diagnosis:
	Takes insulin
	Diagnosis Date:
	Consultation Date:

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	(iii) If exact diagnos	sis is other thar	n Hypertension and	Diabetes please prov	vide details of the below	w questions
	Exact Diagnosi	s:				
	Diagnosis Date	<u>:</u>				
	Medicine Name	e:				
	Please share d	etails of your tr	reatment < name of t	he person proposed	to be insured>	
<ol><li>4.</li><li>5.</li></ol>	Please provide de insured> Date of tests: Type of tests: Findings of tests: Please upload the Was hospitalized in	investigation to past Yes	estigation suggested  ests results S	by your Doctor <nan< th=""><th>please provide the belone of the person proposed to be insured</th><th>sed to be</th></nan<>	please provide the belone of the person proposed to be insured	sed to be
	•					
	Please share detai	is of your past	medical condition			
6.	Is Pregnant Y			ride the below details	;	
7.	If Yes, Kindly tick the Amputation Musculoskeleta Neurological / Polio Spinal cord Stroke Visual / Hearing Others	he specific boxonel / Locomotor Cerebral Palsy	es that are applicab		? Yes No	
	Kindiy provide a d	etalled descrip	tion for all boxes tick	ked above:		
		=	SECTION TO BE FI	=		
	1	-			ld-on/s is /are opted]	
	Cigarette(s)	-			since past	-
	Bidi(s)	-			since past	-
	1	_			since past	_
	Gutka Pouches	-			since past	-
		-			since past	-
	Drugs_(Quantity)	Per Day	Per Week	Per Month	since past	years

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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			

## FOR REFUND (Excess Premium/PPC reimbursement) and for payment of claims credited directly into your bank account

Please provide the following bank details and a copy of a Cancelled Cheque for direct credit into your bank account:

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.
- 2. Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly
- 3. Name on Cancelled Cheque should match with Proposer Name to ensure smooth refund / claim processing
- 4. 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 including the minor/s insured, if any.
- I/ We understand that the information provided by me/ us 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 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 Insurance Company.
- I/We declare and further consent to the Insurance Company to seek medical and other relevant information from any hospital who at any time has attended the person to be insured/proposer or from any past or present employer concerning anything which affects the physical and mental health of the person to be insured / proposer and seeking information from any insurance company to which an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and /or claim settlement.
- I/ We declare and provide my unconditional consent that, pursuant to a claim filed by me/ us, the Insurance Company can seek medical and other relevant information/ documents for me/ us from any Doctor and/ or Hospital where I, or other Insured, had taken treatment i.e. OPD and/ or hospitalization etc.
- I/We authorize the Insurance Company to share information pertaining to my proposal, including the medical records for the sole purpose of underwriting and/ or claims.
- I/ We authorize the Company to process my/ our Personal information for profiling purposes and contact me/ us for (i) communicating for renewal of the Policy, (ii) upsell and/or cross sale of other insurance products.
- I/We authorize the Insurance Company to share my/our Personal Information and other relevant records details with (i) the Law Enforcement Agencies, as and when demanded and (ii) any other vendor as per the requirement etc. like printing the Insurance policy/ renewal reminders or any other such activity.

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- I/ We authorize the Insurance Company to share my/ our Personal Information and/ or medical Information/ records with any Government and/ or Statutory authorities/ bodies, including but not limited to Insurance Regulatory and Development Authority of India (IRDAI), Insurance Information Bureau (IIB) and/ General Insurance Council etc.
- Customer Satisfaction Surveys: I/ We hereby consent to the Insurance Company to use and share my/ our Personal Information with the vendors for the purpose of conducting customer satisfaction surveys and related activities aimed at improving service quality and enhancing the overall customer experience.
- 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/We hereby consent that, in any of the above scenarios, my/ our Personal Information and the medical documents etc. can be shared, and/ or accessed, as the case may be, without any intimation to me/ us.
- 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 HDFCERGO 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 Insurancef 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 / ASSISTANCE DECLARATION**

Declaration in case the proposal is filled by other than the Proposer if the proposer is illiterate or having disability and requires assistance in completing the proposal form (to be certified by someone other than agent/employee of the company)

(The content of this form and its particulars have been explained by me to the Proposer who has understood and confirmed the same.)

Name of the Translator / Representative	
Place	Signature of the Translator /
Date	Representative
Name of the Proposer	
Place	
Date	Signature of the Proposer
	INTERMEDIARY DECLARATION
nature of the questions corresponse(s) submitted by hi will form the basis of the Coby the Company for issuar response(s) is/are containefurnished/ to be furnished, the more if there has been a response to the container of the	clare that I have explained all the contents of this Proposal Form, Including the in this Proposal Form to the Proposer including statement(s), information and a this Proposal Form to questions contained herein or any details sought here in Insurance between the Company and the Proposer, if this Proposal is accepted be Policy. I have further explained that if any untrue statement(s)/information/s Proposal Form/ including addendum(s), affidavits, statements, submissions, pany shall have the right to vary the benefits which may be payable and further losure of any material fact, the policy issued to his/her favor pursuant to this mpany as null and void and all premiums paid under the Policy may be forfeited
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

Intermediary Code:	Branch Location	Signature of Intermediary

**FOR OFFICE USE ONLY** 

ACKNOWLEDGEMENT CUSTOMER COPY				
Received from Mr. / Ms. / Mrs				
Cheque No:	Dated			
Drawn on	Bank for a sum of ₹			
towards payment of premium on behalf of HI	DFC ERGO General Insurance Company Ltd.			
Date Signature & seal				
Neither the submission to us of a completed (	oroposal for insurance nor any payment for any policy sought obliges			

HDFC ERGO General Insurance Company Limited. IRDAI Reg. No.146 CIN: U66030MH2007PLC177117. Registered & Corporate Office: 6th Floor, Leela Business Park, Andheri-Kurla Road, Andheri (East), Mumbai – 400 059. Customer Experience Management, Customer Happiness Center: D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai - 400 078. For Claim/Policy related queries call us at 022 6158 2020 / 022 6234 6234 or Visit Help Section on www.hdfcergo.com for policy copy/tax certificate/make changes/register & track claim. Product Name: my: Optima Secure | Product UIN: HDFHLIP25041V062425 | Product Code - HE/RL/Health/24-25/261l ABCD Chronic Care - HDFHLIA25044V012425 | Parenthood - HDFHLIA25046V012425 my: health Critical Illness - HDFHLIA22141V032122 | my:Health Hospital Cash Benefit (Add-on) - HDFHLIA21271V022021 | IPA Rider – APOPAIP19004V011920 | Optima Wellbeing (Add-on) - HDFHLIA24099V012324.

we will inform you and refund any payment received from you without interest within next 15 days.

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,