

(All fields are mandatory and fill in CAPITALS only)

#Please provide correct mobile number of the proposed insured, to receive information relating to policy servicing and premium acknowledgement.

CUSTOMER INFORMATION

Customer ID:	<input type="text"/>	Loan Account No:	<input type="text"/>	Customers PAN No:	<input type="text"/>
LG code:	<input type="text"/>	LC code:	<input type="text"/>		

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

Address:

DOB: Gender: Male ☐ Female ☐ TG ☐

City: State: Pincode:

Tel.(Res.): (Off.): #Mobile:

E-mail:

Overseas Contact No.: PAN: Passport No:

LIFE INSURED DETAILS TO BE FILLED INCASE DIFFERENT FROM PROPOSER

Name of Life to be Insured Mr. /Ms. /Mrs. (First Name) (Middle Name) (Last Name)

Address:

DOB: Gender: Male ☐ Female ☐ TG ☐

City: State: Pincode:

Tel.(Res.): (Off.): #Mobile:

E-mail:

Overseas Contact No.: Passport No:

FAMILY PHYSICIAN DETAILS

Name of Physician:

Address:

DOB:

City: State: Pincode:

Tel.(Res.): (Off.): #Mobile:

MEDICAL HISTORY OF LIFE INSURED

Have you received any Treatment / Advice / Consultation for any Medical Condition in the last 4 years: Yes ☐ No ☐

If Yes, please fill in the details:

Treatment: Institution:

Doctor's Name:

Contact No: Are you presently taking any medication: Yes ☐ No ☐

If yes specify please:

RISK INFORMATION

Geographic Coverage ☐ Excluding USA/Canada ☐ Including USA/Canada

Specify Countries of visit:

Departure Date Return Date

PLAN DETAILS

Mandatory Base Plan (Please Tick): Bronze ☐ Silver ☐ Gold ☐ Platinum ☐ Standard ☐

Optional: Plus Plan (Please Tick): Yes ☐ No ☐

ADDITIONAL INFORMATION

Name of University:

Address of Institute:

Building Name Block No. Street Name Locality

City State Country Zip Code

Name of Program: Program Duration:

SPONSOR DETAILS

Name of the Sponsor Mr. / Ms. / Mrs. / M/s

DOB: Gender: Male ☐ Female ☐ TG ☐

Address:

City: Pincode:

State: Relationship with Insured:

Tel.(Res.): (Off.): Mobile:

STD Code STD Code

E-mail:

Occupation: ID Proof:

BANK ACCOUNT DETAILS

Name of the Bank Account Holder:

Bank Account No:

Name of Bank: Branch:

MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)

IFSC Code (11 character code appearing on your cheque leaf) Account: Savings ☐ Current ☐

I wish: ☐ Any refund due on the premium payment / any payment/claims will be directly credited to my aforesaid Bank Account.*

*As per IRDAI, it is mandatory that all payments are made to the insured only through electronic mode.

PAYMENT DETAILS

Cheque No: Dated: Amount:

Bank Name:

Bank Account/ LOS No.:

NOMINEE DETAILS

Name of Nominee: Relationship to Insured:

PROPOSER DECLARATION

- I hereby declare that the Insured Person listed above:
- Is / are not traveling against the advice of a physician
 - Is / are not on the waiting list for any medical treatment
 - Is / are not traveling for the purpose of medical treatment
 - Have not received a terminal prognosis for a medical condition before this day
 - I / we have read the Policy Terms and Condition and have accepted the same
 - I / we accept that this policy does not cover treatment for Pre Existing Medical Conditions/Diseases/Ailments that are declared or undeclared
 - I/We hereby declare that the contents of the form and documents have been fully explained to me/us and that I/we have fully understood the significance of the proposed contract.
 - 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 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 further consent to the company. seeking medical information from any doctor or from a 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 authorize HDFC ERGO General Insurance and associate partners to contact me via email, phone, SMS

