HDFC ERGO General Insurance Company Limited



Proposer Mr./ Ms./ Mrs. (First Name) Address District City State "Mobile Email Date of Birth: Gender: Ma Profession: Salaried Self Employed Others Detail									alce it eas				
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r./ Ms./ Mrs.	(First Name)											(I ast Nama)	
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					Pin Code Nationality Get Policy on Email: Yes Male Female TG Marital Status: Married Un PAN No.: I would like to apply for eIA with Karvy CAMS NSDL o policy servicing and premium acknowledgement. ERSON PROPOSED TO BE INSURED hip to Gender* Date of Birth (DDMMYYYY) Sum Insured** Sum Insured** Sum Insured* OMINEE DETAILS yable to the nominee in accordance with the Policy terms and conditions. The nominee must be an immediate to the nominee must be an								
	City Pin Code *Mobile Nationality Get Policy on Email: Yes Irith: Gender: Male Female TG Marital Status: Married Unman Salaried Self Employed Others Detail PAN No. I would like to apply for elA with Karvy CAMS NSDL C **Vide correct mobile number of the proposed insured, to receive information relating to policy servicing and premium acknowledgement. **DETAILS OF THE PERSON PROPOSED TO BE INSURED **DETAILS OF THE PERSON PROPOSED TO BE INSURED **DETAILS OF THE PERSON PROPOSED TO BE INSURED **Name of the Insured person Weight (rms) Weight (rms)												
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ate of Birth:	***Critical Illness Sum Insured** **Same of the 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 er. Nominee for any of the persons proposed to be insured shall be the Proposed. **NoMINEE DETAILS** **NoMINEE** **NoMINEE** **NoMINEE** **NoMINEE** **												
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No. Name of the Insurer	d person	Height	Weight	Relationship to	Gender*	OSE	D TO BE I	Date o	f Birth			Sum Insured**	
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number(s) (Please n	he persons proposed, already mention application number inca tinuously insured: Do you want l	ase of p	pendin	ıg prop	posal.	ith HC	FC E	RGO	Healt				mpany					r insurance o	company?	lf yes, ple	ase indicate below th	e Policy/ Application
Policy No. /	Insurer							Perio	d of l	nsura	nce							Sum Ins	sured (₹)	Clair	ms lodged during the	nreceding years
Application No.	ilisulei			From	(DDN	/MYY	YY)					To (DDMI	MYYY	(Y)			Ouiii iiic	ourcu (t)	Oldii	no loaged during the	preceding years
Please note that con	ntinuity of benefits shall NOT be c	onside	red if t	he Abo	ove qu	estion	ofwar	ntofc	ontinu	ity is r	ot rep	lied a	ffirma	tive, d	etails	are n	ot prov	vided and Po	rtability forn	and relev	ant supporting docume	ents are not submitted.
							N	MEDIC	AL A	ND L	IFE S	TYLI	E INF	ORM.	ATIO	N						
Medical History: P	Please answer the below menti	oned q	questic	ons in	MM -	YY o	f diagr	nosed	l date	(Exa	mple:	if Jar	nuary	2018	then	01 -	18).					
	any of the person proposed t ffering from any of the follow		nsure	d eve	r suf	fered	from/	'		sure /M - Y				ured M - Y				sured 3 M - YY	Insu MM		Insured 5 MM - YY	Insured 6 MM - YY
I. High or low	blood pressure, Chest Pain, o	r any c	other o	cardia	c disc	rder?				-				-				-			-	-
II. Tuberculosi	is, Asthma, Bronchitis or any o	ther lu	ng/res	spirato	ory dis	order				-				-				-			-	-
	ach/Duodenal),liver or gall blac act disorder?	dder di	isorde	r or a	ny oth	ner				-				-				-			-	-

	MED	ICAL AND LIFE STY	LE INFORMATIO	N			
Medic	al History: Please answer the below mentioned questions in MM - YY of diagnose	ed date (Example: if	January 2018 then	01 - 18).			
	tion A: Has any of the person proposed to be insured ever suffered from/ currently suffering from any of the following:	Insured 1 MM - YY	Insured 2 MM - YY	Insured 3 MM - YY	Insured 4 MM - YY	Insured 5 MM - YY	Insured 6 MM - YY
I.	High or low blood pressure, Chest Pain, or any other cardiac disorder?	-	-	-	-	-	-
II.	Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder	-	-	-	-	-	-
III.	Ulcer(Stomach/Duodenal),liver or gall bladder disorder or any other digestive tract disorder?	-	-	-	-	-	-
IV.	Kidney Failure, Stone in kidney or urinary tract, Prostate disorder or any other kidney/urinary tract disorder	-	-	-	-	-	-
V.	Stroke, Epilepsy (fits), Paralysis or any other nervous system (Brain, Spinal cord, etc) disorder	-	-	-	-	-	-
VI.	Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder?	-	-	-	-	-	-
VII.	Tumor (Swelling)-benign or malignant, any external ulcer/growth/ cyst/mass anywhere in the body?	-	-	-	-	-	-
Se	ction B: Has any of the persons proposed to be insured?	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
VIII.	Arthritis, Spondylosis or any other disorder of the muscle/bone/joint	-	-	-	-	-	-
IX.	Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error) ?	-	-	-	-	-	-
Χ.	HIV/AIDS or sexually transmitted diseases or any immune system disorder	-	-	-	-	-	-
XI.	Anaemia, Leukaemia, Lymphoma or any other blood/ lymphatic system disorder	-	-	-	-	-	-
XII.	Psychiatric/ Mental illnesses or sleep disorder	-	-	-	-	-	-
XIII.	Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/Breast disorder?	-	-	-	-	-	-
XIV.	Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy?	-	-	-	-	-	-
XV.	Been under any regular medication (self/ prescribed)?	-	-	-	-	-	-
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?	-	-	-	-	-	-
XVI	. Undertaken any surgery or a surgery been advised and have surgery still pending?	-	-	-	-	-	-
XVI	I. Suffered from any other disease/ illness/ accident/ injury other than common cold or viral fever?	-	-	-	-	-	-
XIX	Is any of the insured pregnant? If yes please mention the expected date of delivery	-	-	-	-	-	-
XX.	Any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy?	-	-	-	-	-	-
Sect	ion C: Additional medical History as per Section A & B above						
Sect	ion D: Name and contact details of the family doctor						
Name				M	obile No.		
	ion E: Does any person proposed to be insured smoke or consume gutkha/ masala or alcohol. If yes please indicate the name and quantity per week.						
Sect	ion F: In respect of any of the persons proposed to be insured (Please tick (/) the check box):		red 1 Insured 2 / No Yes / No	Insured 3 Yes / No		red 5 Insured 6 / No Yes / No
	any application for life, health, hospital daily cash or critical illness insurance eve ed or been made subject to any special conditions by any insurance company?	er been declined, po	stponed,				

loaded or been made	subject to any sp	pecial conditions	by any insurance co	mpany?							ļl	1		<u></u>	<u></u>	!!	
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Premium Amount: ₹							Pay	yment Optior	1:	Cash [#]		Cheque	DD		Credit /	/ Debit (Card
Name of Premium Payer:																	
		(First Name)					(Middle N							(Last Na	me)		

 * Cash towards premium up ₹50,000 will be accepted only at our branch offices.

Amount in words:

Instrument No.:		Instrument Date:			strument nount: ₹					
Bank Name										
MICR Code			IF	SC Code						
The following is an outline of the general e	GENERAL EXCLUSIONS (3,	•			•	this poli	cv		

injury of attempted suicide writine same of insame. Any insured Person's participation of involvement intraval, military of an office operation, racing, diving, availabin, scuba diving, paractruting, nang-griding, clock of montain climbing. Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies. Treatment of Obesity and any weight control program. Plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, Cancer or Burns. Treatment for correction of eye due to refractive error. Circumcisions (unless necessitated by illness or injury and forming part of treatment). Aesthetic or change-of-life treatments of any description such as sex transformation operations, treatments to do or undo changes in appearance driven by cultural habits, fashion or the like or any procedures which improve physical appearance. Save as and to the extent provided for under Ayush Benefit), Non allopathic treatment. Conditions for which Hospitalization is not required. Experimental, investigational or unprove treatment devices and pharmacological regimens. Admission primarily for diagnostic purposes not related to Illness for which Hospitalization has been done. Considering the treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing. Enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. Save as and to the extent provided for under Benefit Spectacles, Contact lenses & Hearing Aids Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products. Artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively). Psychiatric, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), sleep-apnoea. Congenital internal or external diseases, defects or anomalies, genetic disorders. Stem cell therapy or surgery, or growth hormone therapy. Venereal disease, sexually transmitted disease or illness; "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis. Save as and to the extent provided for under Maternity Benefit, Pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy in relation to in-patient only. Sterility, treatment whether to effect or to treat infertility, any fertility, sub-fertility or assisted conception procedure, surrogate or vicarious pregnancy, birth control, contraceptive supplies or services including complications arising due to supplying services. Expenses for organ donor screening, or save as and to the extent provided for in Organ Donor, the treatment of the donor (including surgery to remove organs from a donor in the case of transplant surgery). Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities. Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls (wherever specifically charged for), foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies. vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. Treatments rendered by a Medical Practitioner who is a member of the insured's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments which are not supported by a prescription. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing. Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured, as per Our underwriting guidelines.

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 are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to e 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.
- l/we declare and further 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 authorize HDFC ERGO General Insurance and associate partners to contact me via email, phone, SMS.

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.)

You are obliged to inform HDFC ERGO General Insurance Company Ltd without any delay & in writing of all doctors or other members of medical profession whom you or any of the proposed members have consulted & all changes in your or any other proposed members' state of health between the filing of this application form & inception of your insurance cover. If you are in any doubt, please seek the advice of your insurance advisor.

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 defraud the insurance company or any other person, files a proposal for insurance containing any false information, or conceals for the purpose of misleading, Information cerning 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

shown o	son to Take out or renew or continue an insurance policy in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission pay 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 p as of Section 41 of the Insurance Act 1938, as amended, shall be punishable with a fine which may extend to ₹10 Lakhs.	
Place		
Date	D D M M Y Y Y	Signature of the Proposer

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Name of the	e Translator								
Place									
Date	D D M M Y	<u> </u>						Signature	of theTranslate
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	D D M M Y								
Date							Signature / Thumb	Impression	n of the Prop
nformation a f this Propos affidavits, sta policy issued	and response(s) submitt sal is accepted by the C atements, submissions, d to his/her favour pursua	by declare that I have explained a ed by him/her in this Proposal Forr ompany for issuance of the Policy furnished/to be furnished, the Con int to this Proposal may be treated nt/Broker/Relationship Officer)	Il the contents of this Proposal F n to questions contained herein n. I have further explained that it npany shall have the right to va	Form, including the or any details sougl f any untrue staten ary the benefits whi	nature of the questi nt herein will form the lent(s)/ information/ ch may be payable	ons contained in the basis of the Continesponse(s) is/are and further more if	ract of Insurance between e contained in this Propose f there has been a non-dis	Proposer incluthe Company al Form/inclustic sclosure of ar	uding statemer y and the Propo ding addendur
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3	Critical Illness upto 50%	6 of SI		3	Critical Illness u	pto 50% of SI			
4	Critical Illness upto 100	% of SI		4	Critical Illness u	pto 100% of SI			
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6	Hospital Daily Cash for	60 days		6	Hospital Daily C	ash for 60 days			
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_	Maternity Sum insured								
	Dental Cover			_					
		nses and/or Hearing Aid		\dashv					
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	ment of premium on be	half of HDFC ERGO General Insi Y	ırance Company Ltd.		\$	Signature & seal _			
accept a pro	posal for insurance, it s	npleted proposal for insurance nor hall be subject to the policy terms ou and refund any payment receive	and conditions and we shall have	ve no liability to mal					

VERNACULAR DECLARATION