

HDFC ERGO General Insurance Company Limited

Critical Illness - Proposal Form



(Fields marked with asterisk (*) are mandatory and fill in CAPITALS only) Application Number _____ Branch Manger Code _____ TSE Code _____

Sourcing Channel / Agent / Broker Name:

CP Code Sourcing Branch (City):

PROPOSER DETAILS

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

Address:

City: Pin Code: *Sex: Male ☐ Female ☐

State: *Proposer Date of Birth:

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

STC Code STD Code

Email:

ID Proof Type: ☐ PAN ☐ Passport ☐ Driving License ☐ Voters Card ☐ Others

eIA: Aadhar Card: PAN:

PLAN DETAILS

*Plan Name: ☐ Silver *Proposed Policy Period: to

DETAILS OF THE PERSON PROPOSED TO BE INSURED

Sr.No.	*Name of the Insured person	*Relationship	*Gender*	*Date of Birth	*Sum Insured

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

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. For all other persons proposed to be insured, the Proposer shall be the Nominee.

Name: _____ Relationship: _____

EXISTING/PREVIOUS INSURANCE DETAILS

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

PREMIUM DETAILS

Amount Rs. Rupees: _____

SOURCES OF FUND

Salary: ☐ Business: ☐ Other: ☐ (Please Specify): _____

BANK ACCOUNT DETAILS

Name of the Bank Account Holder:

Bank Account No.: Name of Bank:

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

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 the IRDAI, its mandatory that all payments made to the insured only through electronic mode.

*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. Diabetes, Thyroid Disorder or any other endocrine disorder		9. Diseases of the Nose/Ear/Throat/Dental/Eye (please mention diopthers)	
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, Leukemia 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. Tuberculosis, Asthma, Bronchitis or any other lung/respiratory 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 detoxicating 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			

ACKNOWLEDGMENT - CUSTOMER COPY

Please retain this counterfoil for your records

