HDFC ERGO General Insurance Company Limited

Proposal Form

my: Optima Secure - Master Proposal Form Only for Employer – Employee Proposals

Application No: _____

PHOTOGRAPH

1. 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".
3. For Employer-Employee proposals, it is mandatory for Employee (who is considered as a Primary Insured for filling this form) to be an Insured Person.
4. For Employer-Employee proposals, Premium/Refunds shall be paid by/to the Employer and claims shall be paid to Employee.

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 Code	Intermediary Name	Intermediary Number

PROPOSER DETAILS (EMPLOYER WHICH INCLUDES COMPANY / ENTITY) DETAILS

Name of the Company / Entity / Employer:

Date of Incorporation / Registration in case of Company:

Address:

E-Mail of the Authorized Signatory:

GSTIN / UIN (if any):

Contact Number of the Authorized Signatory:

Permanent Account Number (PAN):

Nature of Business: _____

Industry Type: Antique dealer ☐ Art dealer ☐ Jewellery ☐ Import-Export ☐ Mining ☐
Shipping ☐ Scrap Dealing ☐
Agriculture ☐ Stock Broking ☐ BFSI ☐ Real Estate ☐ Manufacturing ☐
☐ If Others, please specify _____

Organization Type: Government ☐ Public Limited ☐ Partnership ☐ Proprietor ☐
Private Limited ☐ Trust ☐ HUF ☐ Section 8 Company

DECLARATION & CONSENT PROVIDED BY EMPLOYER

_____<name of Company> hereby declares and provides consent to Employee (Mr. / Ms. _____ <name of Employee>), who is the Primary Insured under the policy, to provide all details requested legitimately in this form on behalf of all persons proposed to be insured under the Policy.

_____<name of Company> hereby declares and provides consent to the Insurer, that any payment to the Employee or any other Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Insurer to the extent of that amount for the particular claim.

Signature of Company Authorized Signatory: _____

Time: _____ Date: _____ Place: _____

EMPLOYEE DETAILS

Name of the Employee (Primary Insured):

Date of Birth: Nationality:

Residential Status: ☐ Resident Indian ☐ NRI ☐ OCI

Current Country of Residence:

Address:

☐ Please tick if your permanent address is same as above. If not, kindly fill the below:

Permanent Address:

E-Mail:

GSTIN / UIN (if any):

Marital Status: ☐ Married ☐ Unmarried

Contact Number:

Permanent Account Number (PAN):

Passport Number:

I have eIA: ☐ Yes ☐ No

I would like to apply for eIA Kavy ☐ CAMS ☐ NSDL ☐ CDSL ☐

Annual Income: Upto 2.5 Lakh ☐ 2.5 Lakh to 5 Lakh ☐ 5 Lakh to 15 Lakh ☐ 15 Lakh to 30 Lakh ☐ Above 30 Lakh ☐

Education Level ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Employee ID (Employees of HDFC Group and Munich Re Group):

☐☐

Policy Number of any active HDFC ERGO Policy where you are the Policyholder:

☐☐

CKYC No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Are you a Politically Exposed Person (PEP) or family member/ close relative / associate of PEP: ☐ Yes ☐ No

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

Occupation: Salaried ☐ Self Employed ☐ Business Owner ☐ Student ☐ Housewife ☐ Retired ☐ Others ☐

If others, please select source of income whichever is applicable:

Rentals ☐ Interest ☐ Pension ☐ Investment ☐

Industry Type: Antique dealer ☐ Art dealer ☐ Jewellery ☐ Import-Export ☐ Mining ☐ Shipping ☐ Scrap Dealing ☐ Agriculture ☐ Stock Broking ☐ BFSI ☐ Real Estate ☐ Manufacturing ☐

☐ If Others, please specify ____________________

Is your total aggregate premium across all products with HDFC ERGO General Insurance Company Limited more than INR 2 lakhs? ☐ Yes ☐ No

Do you have an annual income of INR 50 lakhs or above ☐ Yes ☐ No

Is your total aggregate premium across all retail products with HDFC ERGO General Insurance Company Limited INR 30 lakhs or more? ☐ Yes ☐ No

DETAILS OF THE PERSON(S) PROPOSED TO BE INSURED

S. No	Name	Date of Birth	Gender (M/F/ TG)	Height (in cms)	Weight (in kgs)	Relationship with Proposer	ABHA ID (if available)
1							
2							
3							
4							
5							
6							

Note: In case any insured person(s) wish to generate his/her ABHA ID. Kindly visit the link:

https://healthid.ndhm.gov.in/register

PREMIUM TIER (PLEASE TICK)					
Tier 1 ☐	**Tier 2** ☐	**Tier 3** ☐	**Tier 4** ☐	**Tier 5** ☐	**Tier 6** ☐

Classification of Cities for Premium Tier

- Tier 1: Delhi, Surat, Gurugram, Faridabad, Ghaziabad, Greater Noida.
- Tier 2: Mumbai, Mumbai Suburban, Thane, Navi Mumbai, Ahmedabad, Vadodara
- Tier 3: Nashik, Rest of NCR, Amritsar, Ahmednagar, Mathura, Aligarh
- Tier 4: Kolkata, Rest of Gujarat, Telangana, Agra, Ludhiana, Beed, Jalgaon, Indore, Gwalior
- Tier 5: Rest of Maharashtra, Rest of Uttar Pradesh, Rest of Madhya Pradesh, Rest of Rajasthan, Rest of Haryana, Howrah, Hooghly, North 24 Parganas, South 24 Parganas
- Tier 6: Rest of Indira

No co-payment shall apply if Insured Person from Tier 4 avails a treatment in Tier 1.

NOMINEE DETAILS										
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

Note:

1. The nominee must be an immediate relative of the Proposer. Nominee for any of the persons proposed to be insured shall be the Proposer.
2. Name of Nominee should be as per bank records to ensure smooth processing

POLICY DETAILS	
Policy Type	Individual ☐ Family ☐ Floater ☐
Tenure	1 Year ☐ 2 Year ☐ 3 Year ☐ 4 Year ☐ 5 Year ☐
Policy Period	From _____ To _____
Plan	Optima Suraksha ☐ Optima Secure ☐ Optima Super Secure ☐ Optima Secure Global ☐ Optima Secure Global Plus ☐ Optima Select ☐ Optima Lite ☐ Optima Secure+ ☐

BASE SUM INSURED IN ₹				
5 Lakhs ☐	7.5 Lakhs ☐	10 Lakhs ☐	15 Lakhs ☐	20 Lakhs ☐
25 Lakhs ☐	50 Lakhs ☐	75 Lakhs ☐	100 Lakhs ☐	200 Lakhs ☐

For Optima Suraksha: Maximum Base Sum insured limit is 50 Lakhs

For Optima Secure Global: Base Sum Insured available is 100 Lakhs & 200 Lakhs

For Optima Secure Global Plus: Base Sum Insured available is 25 Lakhs, 50 Lakhs, 75 Lakhs, 100 Lakhs & 200 Lakhs

Base Sum Insured limit of 75 Lakhs is available only under Optima Secure Global Plus

For Optima Select: Base Sum Insured available is 5 Lakhs, 7.5 Lakhs, 10 Lakhs, 15 Lakhs, 20 Lakhs & 25 Lakhs.

For Optima Lite: Base Sum Insured available is 5 Lakhs & 7.5 Lakhs.

Please refer to annexure A (Plan Chart) for coverage details which varies with Base Sum Insured & Plan chosen

OPTIONAL COVERS					
S. No.	**Optional Cover**		**Sum Insured Options**	**Sum Insured**	**Deductible**
1	Emergency Air Ambulance	☐	Upto Rs. 5 Lakhs	NA	NA
2	Daily Cash for Shared Room	☐	₹ 800, up to 4,800 ☐ ₹ 1,000, up to 6,000 ☐	NA	NA
3	Protect Benefit	☐	Up to Base Sum Insured	NA	NA
4	Plus Benefit	☐	50% of Base Sum Insured for each Policy Year, maximum up to 100%	NA	NA
5	Secure Benefit	☐	100% of Base Sum Insured ☐ 200% of Base Sum Insured ☐	NA	NA
6	Automatic Restore Benefit	☐	NA	NA	NA
7	Aggregate Deductible	☐	NA	NA	☐ ₹10,000

OPTIONAL COVERS					
	(Applicable only for claims arising within India)				☐ ₹25,000 ☐ ₹50,000 ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000 ☐ ₹5,00,000 ☐ ₹10,00,000 ☐ ₹20,00,000 ☐ ₹25,00,000
	Note: a. Preventive health check-up benefit will not be available under the policy if Aggregate Deductible of INR 5 Lakhs is in force. b. Preventive Health Check-up, Secure Benefit, Cumulative Bonus / Plus Benefit / Infinite Benefit, Automatic Restore Benefit, Daily Cash for Shared Room and Unlimited Restore (Add-on) benefits will not be available under the policy if Aggregate Deductible of INR 10 Lakhs or more is in force. c. 5L / 10L Deductible can only be opted with Base Sum Insured >= 25 L d. 20L / 25L Deductible can only be opted with Base Sum Insured >= 50 L e. Coverage for Aggregate Deductible shall be on Individual basis if the base plan is on individual sum insured basis OR on floater basis if the base plan is on floater sum insured basis. f. For 'Optima Select' Aggregate Deductible options are from 10K to 10 Lakhs. g. For 'Optima Lite' Aggregate Deductible options are from 10K to 50K.				
8	E-Opinion for Critical Illness	☐	NA	NA	NA
9	Global Health Cover (Emergency Treatments Only)	☐	NA	NA	NA
10	Global Health Cover (Emergency & Planned Treatments)	☐	NA	NA	NA
11	Overseas Travel Secure (Option available only with Global Plans)	☐	Accommodation: (Upto Rs. 15,000/day, maximum up to 30 days)	NA	NA

OPTIONAL COVERS					
			Airfare: At Actuals		
12	Preventive Health Check-Up	☐	This option is available for selection in Optima Select plan only	NA	NA
13	PED waiting period modification (allowed to be opted at channel level only)	☐	36 months / 3 years (default)	NA	NA
			☐ 24 months / 2 years	NA	NA
			☐ 12 months / 1 year	NA	NA
14	Modification of Room Rent		☐ Room Rent: At actuals and ICU: At Actuals (default) (This option is available for selection in Optima Select plan only)	NA	NA
			☐ Room Rent: Upto 1% of BSI and ICU: Upto 2% of BSI (This option is applicable only for & inbuilt in Optima Lite plan)		
		☐	☐ Room Rent: Single Pvt. Room and ICU: At Actuals (This option is inbuilt in Optima Select plan; & available for selection in only Optima Secure, Optima Super Secure & Optima Secure + plans)	NA	NA
			☐ Room Rent: Shared room and ICU: At Actuals (This option is available for selection in Optima Select plan only)	NA	NA
15	Modification of Pre-Hospitalization expenses – Days		60 days (default)	NA	NA
		☐	☐ 30 days (This option is applicable only for & inbuilt in Optima Lite plan)		

16	Modification of Post-Hospitalization expenses – Days	☐	180 days(default) ☐ 60 days (This option is applicable only for & inbuilt in Optima Lite plan)	NA	NA
17	Modification of Cumulative Bonus	☐	10% of BSI upto 100% (default) ☐ 25% of BSI upto 100% (This option is applicable only for & inbuilt in Optima Select plan)	NA	NA
18	Infinite Benefit	☐	100% of Base Sum Insured for each Policy Year (inbuilt in Optima Secure + plan and optional only for Optima Super Secure plan)	NA	NA
19	Protect Benefit	☐	Option to remove benefit (available in only Optima Secure, Optima Super Secure & Optima Secure + plans)	NA	NA

Notes pertaining to Optional Covers:

1. BSI means Base/Basic Sum Insured opted
2. Optional Covers stipulated in the table above can only be opted and will only be available in conjunction with details mentioned in Annexure - A

ADD-ON COVERS					
1	my: health Critical Illness (You can opt for a Sum Insured from 1 Lakh to 500 Lakhs)	☐ **Plan 1** (9 Illnesses)	☐ **Plan 2** (12 Illnesses)	☐ **Plan 3** (15 Illnesses)	☐ **Plan 4** (18 Illnesses)
		☐ **Plan 5** (25 Illnesses)	☐ **Plan 6** (40 Illnesses)	☐ **Plan 7** (51 Illnesses)	
2	Unlimited Restore (Add-on)	☐ Yes ☐ No			
3 (a)	my:health Hospital Cash Benefit	☐ Yes ☐ No			
3 (b)	Hospital Cash benefit – Global (Optional cover)	☐ Yes ☐ No			
4	Optima Wellbeing (Add on)	☐ Yes ☐ No			
5	Limitless	☐ Yes ☐ No			
6	Parenthood	☐ ₹ 50K	☐ ₹ 100K	☐ ₹ 150K	☐ ₹ 200K
7	Serious Illness Booster	☐ Yes ☐ No			

S. No.	Name	ABCD Chronic Care (If opted kindly tick below)	my: health Critical Illness Sum Insured in ₹	my: health Hospital Cash Benefit Sum Insured Per Day Sum Insured (in '000 ₹)						
				0.5	1	2	3	5	7.5	10
1		☐								
2		☐								
3		☐								
4		☐								
5		☐								
6		☐								

Notes pertaining to Add-on covers

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. Coverage for 'Unlimited Restore', 'Serious Illness Booster' benefit shall be on Individual basis if the base plan is on individual sum insured basis OR on floater basis if the base plan is on floater sum insured basis.
d. Unlimited Restore (add-on) is not available with 'Optima Select', 'Optima Lite' and 'Optima Secure+' plans.
e. Regardless of whether the base plan is on individual sum insured basis OR on floater basis, 'Limitless' Add-on shall cease to exist for lifetime if the benefits for the said Add-on are completely utilized by even a single Insured Person under the Policy.
f. 'Parenthood' can be opted if at least 1 female of 18 year or above is insured under the Base plan.

NRI DISCOUNT AND OTHER ITEMS

NRI Discount

1. Do you want to avail NRI Discount? (This option is available only if all proposed insured person(s) under the policy are NRIs / OCIs) ☐ Yes ☐ No

Note pertaining to NRI Discount:

a. For continuity of NRI discount, at each renewal you have to further declare that all Insured Person(s) are still NRIs / OCIs and residing overseas.

b. If at renewal NRI / OCI status of any of the Insured Person(s) in the policy is not attained, NRI discount shall not be provided to the entire policy.

Other Items

Go Green and make a difference to our planet! We shall provide you with soft copy of your Policy at your registered e-mail id.

Note: Soft copy of your policy can be easily accessed at your fingertips to refer to terms and conditions, for lodging claims and for any other service needs.

☐ Additionally, by ticking the check box we understand that you wish to have a physical copy of your policy.

For details on the process to receive your physical policy kindly visit "Help" section on www.hdfcergo.com or contact our customer care for the same

EXISTING/PREVIOUS INSURANCE POLICY DETAILS

Does any person proposed to be insured presently hold any Health Insurance/Critical Illness Insurance Policies from HDFC ERGO or any other Insurer?

If Yes, please provide below details

Policy No. / Application No.	Name of the Insured	Name of the Insurer	Period of Insurance DD/MM/YYYY To DD/MM/YYYY		Sum Insured	Claims lodged during the preceding years(Y/N)	To be considered for continuity (Y/N)

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:

☐ I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that I/We do not hold any Health Insurance / Critical Illness Policy from HDFC ERGO or any other insurer.

Please fill in the below details **on behalf of all person(s) proposed to be insured** for calculating Favourable Claims Experience Discount.

Kindly note: In-case of misrepresentation or non-disclosure the company in addition to Policy cancellation, has also right to recover or adjust the discounted premium either from Policy renewal premium or Claims.

1. Was there a hospitalization claim made under the existing health insurance policy during the current policy year with existing insurer?
   - ☐ Yes
   - ☐ No

2. Was there a hospitalization claim made under any health insurance policy during the policy year prior to the one in question 1 above
   - ☐ Yes
   - ☐ No
   - ☐ Not Applicable [Only have a health Insurance since 1 year]

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

Please select Medical Question for<name of the person proposed to be insured>

1. Has an ailment or disability or deformity including due to accident or congenital disease ☐ Yes ☐ No
2. Has planned a surgery ☐ Yes ☐ No
3. Takes medicines regularly ☐ Yes ☐ No
4. Has been advised investigation or further tests ☐ Yes ☐ No
5. Was hospitalized in the past ☐ Yes ☐ No
6. 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

ADDITIONAL MEDICAL QUESTIONS **[RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]**

1. 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
- ☐ 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 disorder
- ☐ 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 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 pressure

Exact Diagnosis:

Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? ☐ Yes ☐ No

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ 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) 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 ☐ GDM (Gestational Diabetes)

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: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

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 planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details

Please share details of surgery <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

Please share details of your past surgery<name of the person proposed to be insured>

3. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details

Please 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? ☐ Yes ☐ 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 of the person proposed to be insured>

4. Has been advised investigation or further tests ☐ Yes ☐ No. If Yes, please provide the below details

Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>

Date of tests: _____

Type of tests: _____

Findings of tests: _____

Please upload the investigation tests results

5. Was hospitalized in past ☐ Yes ☐ No. If Yes, please provide the below details

Please share details for your past medical condition <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Please share details of your past medical condition

6. Is Pregnant ☐ Yes ☐ No. If Yes, please provide the below details

Please share your expected delivery date with us

7. Are you having any disability/ deformity including accidental or congenital? ☐ Yes ☐ No

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: _____

LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]

[TO BE FILLED ONLY IF my: health Critical Illness and/or Global Health Cover (Emergency Treatments Only) or Global Health Cover (Emergency & Planned Treatments) optional covers 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

MEDICAL & LIFESTYLE QUESTIONS FOR PERSON PROPOSED TO BE INSURED

[TO BE REPEATED FOR EACH PERSON PROPOSED TO BE INSURED]

INSURED - 2

Please select Medical Question for<name of the person proposed to be insured>

1. Has an ailment or disability or deformity including due to accident or congenital disease ☐ Yes ☐ No
2. Has planned a surgery ☐ Yes ☐ No
3. Takes medicines regularly ☐ Yes ☐ No
4. Has been advised investigation or further tests ☐ Yes ☐ No
5. Was hospitalized in the past ☐ Yes ☐ No
6. 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

ADDITIONAL MEDICAL QUESTIONS [RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]

8. 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

- ☐ 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 disorder
- ☐ 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 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 pressure

Exact Diagnosis:

Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? ☐ Yes ☐ No

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ 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) 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 ☐ GDM (Gestational Diabetes)

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: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

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: _____

9. Has planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details

Please share details of surgery <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

Please share details of your past surgery<name of the person proposed to be insured>

10. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details

Please 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? ☐ Yes ☐ 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 of the person proposed to be insured>

11. Has been advised investigation or further tests ☐ Yes ☐ No. If Yes, please provide the below details

Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>

Date of tests: _____

Type of tests: _____

Findings of tests: _____

Please upload the investigation tests results

12. Was hospitalized in past ☐ Yes ☐ No. If Yes, please provide the below details

Please share details for your past medical condition <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Please share details of your past medical condition

13. Is Pregnant ☐ Yes ☐ No. If Yes, please provide the below details

Please share your expected delivery date with us

14. Are you having any disability/ deformity including accidental or congenital? ☐ Yes ☐ No

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: _____

LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]

[TO BE FILLED ONLY IF my: health Critical Illness and/or Global Health Cover (Emergency Treatments Only) or Global Health Cover (Emergency & Planned Treatments) optional covers 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

MEDICAL & LIFESTYLE QUESTIONS FOR PERSON PROPOSED TO BE INSURED

[TO BE REPEATED FOR EACH PERSON PROPOSED TO BE INSURED]

INSURED - 3

Please select Medical Question for<name of the person proposed to be insured>

1. Has an ailment or disability or deformity including due to accident or congenital disease ☐ Yes ☐ No
2. Has planned a surgery ☐ Yes ☐ No
3. Takes medicines regularly ☐ Yes ☐ No
4. Has been advised investigation or further tests ☐ Yes ☐ No
5. Was hospitalized in the past ☐ Yes ☐ No
6. 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

ADDITIONAL MEDICAL QUESTIONS **[RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]**

15. 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
- ☐ 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 disorder
- ☐ 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 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 pressure

Exact Diagnosis:

Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? ☐ Yes ☐ No

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ 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) 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 ☐ GDM (Gestational Diabetes)

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: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

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: _____

16. Has planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details

Please share details of surgery <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

Please share details of your past surgery<name of the person proposed to be insured>

17. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details

Please 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? ☐ Yes ☐ 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 of the person proposed to be insured>

18. Has been advised investigation or further tests ☐ Yes ☐ No. If Yes, please provide the below details

Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>

Date of tests: _____

Type of tests: _____

Findings of tests: _____

Please upload the investigation tests results

19. Was hospitalized in past ☐ Yes ☐ No. If Yes, please provide the below details

Please share details for your past medical condition <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Please share details of your past medical condition

20. Is Pregnant ☐ Yes ☐ No. If Yes, please provide the below details

Please share your expected delivery date with us

21. Are you having any disability/ deformity including accidental or congenital? ☐ Yes ☐ No

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: _____

LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]

[TO BE FILLED ONLY IF my: health Critical Illness and/or Global Health Cover (Emergency Treatments Only) or Global Health Cover (Emergency & Planned Treatments) optional covers 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

MEDICAL & LIFESTYLE QUESTIONS FOR PERSON PROPOSED TO BE INSURED

[TO BE REPEATED FOR EACH PERSON PROPOSED TO BE INSURED]

INSURED - 4

Please select Medical Question for<name of the person proposed to be insured>

1. Has an ailment or disability or deformity including due to accident or congenital disease ☐ Yes ☐ No
2. Has planned a surgery ☐ Yes ☐ No
3. Takes medicines regularly ☐ Yes ☐ No
4. Has been advised investigation or further tests ☐ Yes ☐ No
5. Was hospitalized in the past ☐ Yes ☐ No
6. 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

ADDITIONAL MEDICAL QUESTIONS [RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]

22. 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
- ☐ 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 disorder
☐ 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 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 pressure
Exact Diagnosis:
Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? ☐ Yes ☐ No
Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ 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) 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 ☐ GDM (Gestational Diabetes)
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: ☐ Medical ☐ Surgical
Complications / Recurrence: ☐ Yes ☐ No
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: _____

23. Has planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details

Please share details of surgery <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

Please share details of your past surgery<name of the person proposed to be insured>

24. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details

Please 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? ☐ Yes ☐ 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 of the person proposed to be insured>

25. Has been advised investigation or further tests ☐ Yes ☐ No. If Yes, please provide the below details

Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>

Date of tests: _____

Type of tests: _____

Findings of tests: _____

Please upload the investigation tests results

26. Was hospitalized in past ☐ Yes ☐ No. If Yes, please provide the below details

Please share details for your past medical condition <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Please share details of your past medical condition

27. Is Pregnant ☐ Yes ☐ No. If Yes, please provide the below details

Please share your expected delivery date with us

28. Are you having any disability/ deformity including accidental or congenital? ☐ Yes ☐ No

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: _____

LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]

[TO BE FILLED ONLY IF my: health Critical Illness and/or Global Health Cover (Emergency Treatments Only) or Global Health Cover (Emergency & Planned Treatments) optional covers 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

MEDICAL & LIFESTYLE QUESTIONS FOR PERSON PROPOSED TO BE INSURED

[TO BE REPEATED FOR EACH PERSON PROPOSED TO BE INSURED]

INSURED - 5

Please select Medical Question for<name of the person proposed to be insured>

1. Has an ailment or disability or deformity including due to accident or congenital disease ☐ Yes ☐ No
2. Has planned a surgery ☐ Yes ☐ No

3.	Takes medicines regularly	☐ Yes	☐ No
4.	Has been advised investigation or further tests	☐ Yes	☐ No
5.	Was hospitalized in the past	☐ Yes	☐ No
6.	Is Pregnant (Applicable for females >=18 years and <=55 years.)	☐ Yes	☐ No
7.	Are you having any disability/ deformity including accidental or congenital?	☐ Yes	☐ No

ADDITIONAL MEDICAL QUESTIONS **[RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]**

29. 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
- ☐ 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 disorder
- ☐ 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 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 pressure

Exact Diagnosis:

Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? ☐ Yes ☐ No

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ 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) 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 ☐ GDM (Gestational Diabetes)

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: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

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: _____

30. Has planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details

Please share details of surgery <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

Please share details of your past surgery<name of the person proposed to be insured>

31. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details

Please 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? ☐ Yes ☐ 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 of the person proposed to be insured>

32. Has been advised investigation or further tests ☐ Yes ☐ No. If Yes, please provide the below details

Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>

Date of tests: _____

Type of tests: _____

Findings of tests: _____

Please upload the investigation tests results

33. Was hospitalized in past ☐ Yes ☐ No. If Yes, please provide the below details

Please share details for your past medical condition <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Please share details of your past medical condition

34. Is Pregnant ☐ Yes ☐ No. If Yes, please provide the below details

Please share your expected delivery date with us

35. Are you having any disability/ deformity including accidental or congenital? ☐ Yes ☐ No

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: _____

LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]

[TO BE FILLED ONLY IF my: health Critical Illness and/or Global Health Cover (Emergency Treatments Only) or Global Health Cover (Emergency & Planned Treatments) optional covers

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

MEDICAL & LIFESTYLE QUESTIONS FOR PERSON PROPOSED TO BE INSURED
[TO BE REPEATED FOR EACH PERSON PROPOSED TO BE INSURED]
INSURED - 6

Please select Medical Question for<name of the person proposed to be insured>

1. Has an ailment or disability or deformity including due to accident or congenital disease ☐ Yes ☐ No
2. Has planned a surgery ☐ Yes ☐ No
3. Takes medicines regularly ☐ Yes ☐ No
4. Has been advised investigation or further tests ☐ Yes ☐ No
5. Was hospitalized in the past ☐ Yes ☐ No
6. 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

ADDITIONAL MEDICAL QUESTIONS **[RELEVANT SECTION TO BE DISPLAYED WHEN ANSWERED YES IN PREVIOUS QUESTION]**

36. 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
- ☐ 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 disorder
- ☐ 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 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 pressure
Exact Diagnosis:
Are you taking any anti-platelets/anti-coagulants/Blood thinning agents/Anti Lipids? ☐ Yes ☐ No
Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ 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) 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 ☐ GDM (Gestational Diabetes)
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: ☐ Medical ☐ Surgical
Complications / Recurrence: ☐ Yes ☐ No
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: _____

37. Has planned a surgery ☐ Yes ☐ No. If Yes, please provide the below details
Please share details of surgery <name of the person proposed to be insured>
Exact Diagnosis: _____
Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

Please share details of your past surgery<name of the person proposed to be insured>

38. Takes medicines regularly ☐ Yes ☐ No. If Yes, please provide the below details

Please 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? ☐ Yes ☐ 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 of the person proposed to be insured>

39. Has been advised investigation or further tests ☐ Yes ☐ No. If Yes, please provide the below details

Please provide details about investigation suggested by your Doctor <name of the person proposed to be insured>

Date of tests: _____

Type of tests: _____

Findings of tests: _____

Please upload the investigation tests results

40. Was hospitalized in past ☐ Yes ☐ No. If Yes, please provide the below details

Please share details for your past medical condition <name of the person proposed to be insured>

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Please share details of your past medical condition

41. Is Pregnant ☐ Yes ☐ No. If Yes, please provide the below details

Please share your expected delivery date with us

42. Are you having any disability/ deformity including accidental or congenital? ☐ Yes ☐ No

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: _____

LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]

[TO BE FILLED ONLY IF my: health Critical Illness and/or Global Health Cover (Emergency Treatments Only) or Global Health Cover (Emergency & Planned Treatments) optional covers 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

PAYMENT DETAILS

Premium Details: Amount Rs. _____

Premium Payment Options: ☐ Single/Monthly ☐ Quarterly ☐ Half Yearly ☐ Annual

Premium Payment Options: ☐ Cheque ☐ DD ☐ Card ☐ ECS ☐ Wallet ☐ Bima-ASBA*

Instrument Details: _____

Date: _____

Note:

- ***BASBA/Bima-ASBA- Bima Applications Supported by Blocked Account.***
- ☑ *I hereby give my consent and authorise my bank to block the premium amount payment and debit the same from my account under Bina-ASBA facility on acceptance of my proposal for Insurance by HDFC ERGO General Insurance Company Limited. In case the proposal is not accepted, I accord my consent to debit only the expenses incurred towards medical examination, if any and unblock the balance amount*

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:

DETAILS PERTAINING TO EMPLOYER / COMPANY / ENTITY			
Cheque No		Name as in Bank Account	
Bank Name		Bank Account No	
Branch Name		IFSC Code	
Cheque Date		MICR Code	
Cheque Amount for ₹			

DETAILS PERTAINING TO EMPLOYEE			
Cheque No		Name as in Bank Account	
Bank Name		Bank Account No	
Branch Name		IFSC Code	
Cheque Date		MICR Code	
Cheque Amount for ₹			

Note:

1. The Employer / Company / Entity and Employee 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 Employer / Company / Entity and Employee Name to ensure smooth refund / claim processing.
4. For Employer-Employee proposals, bank details of both Employer as well as Employee are needed. Basis such bank details provided Premium/Refunds shall be paid by/to the Employer and claims shall be paid to Employee.
5. If ECS is selected, please submit the standing instruction form available at our branches.

DECLARATION, CONSENT & WARRANTY PROVIDED BY PRIMARY INSURED (EMPLOYEE) 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.
- 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 Company Authorized Signatory: _____

Date: _____ Time: _____ Place: _____

Signature of the Primary Insured (Employee): _____

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.)

Anti-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 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 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.10Lakhs.

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: _____ _____

Date: _____ Signature of the Translator / Representative

Name of the Primary Insured (Employee): _____

Place: _____ _____

Date: _____ Signature of the Primary Insured (Employee)

INTERMEDIARY DECLARATION

I, _____(Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Intermediary/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, Including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought here in will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/ including addendum(s), affidavits, statements, submissions, furnished/ to be furnished, the company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favor pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

Signature of Intermediary: _____

Date: _____

Place: _____ Time: _____

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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

FOR OFFICE USE ONLY

Intermediary Code: _____ Branch Location: _____

Signature of Intermediary: _____

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ACKNOWLEDGEMENT CUSTOMER COPY

Received from Mr. / Ms. / Mrs. _____

Cheque No: _____ Cheque Date: _____

Drawn on Bank for a sum of ₹_____ towards payment of premium on behalf of HDFC ERGO General Insurance Company Ltd.

Date: _____ Signature & Seal: _____

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges 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, we will inform you and refund any payment received from you without interest within next 15days.

Annexure A - Plan Chart:

SCHEDULE OF BENEFITS									
Section	**Plans**	**Optima Suraksha**	**Optima Secure**	**Optima Super Secure**	**Optima Secure Global**	**Optima Secure Global Plus**	**Optima Select**	**Optima Lite**	**Optima Secure+**
All figures in ₹	Base Sum Insured per Insured Person per Policy Year (in Lakh)	5 / 10 / 15 / 20 / 25 / 50 Lakhs	5 / 10 / 15 / 20 / 25 / 50 / 100 / 200 Lakhs	10 / 15 / 20 / 25 / 50 / 100 / 200 Lakhs	100 / 200 Lakhs	25 / 50 / 75 / 100 / 200 Lakhs	5 / 7.5 / 10 / 15 / 20 / 25 Lakhs	5 / 7.5 Lakhs	5/10/15/20/ 25/50/ 100/200 Lakhs
	^Geography	India only	India only	India only	Worldwide including India	Worldwide including India	India only	India only	India only
1.1	Hospitalization Expenses	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
1.1.a	Room Rent	At Actuals	At Actuals	At Actuals	At Actuals	At Actuals	Upto Single Private room	Upto 1% of base sum insured per day	At Actuals
1.1.b	ICU	At Actuals	At Actuals	At Actuals	At Actuals	At Actuals	At Actuals	Upto 2% of base sum insured per day	At Actuals
1.1.1. i.	Road Ambulance	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured
1.1.1. ii.	Dental Treatment	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured
1.1.1. iii.	Plastic surgery	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured
1.1.1. iv.	Day Care Treatment	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured
1.2	Home Healthcare	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured (India only)	Covered upto sum insured (India only)	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured
1.3	Domiciliary Hospitalization	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured (India only)	Covered upto sum insured (India only)	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured
1.4	AYUSH Treatment	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured
1.5	Pre-Hospitalization	60 days	60 days	60 days	60 days (India only)	60 days	60 days	30 days	60 days
1.6	Post-Hospitalization	180 days	180 days	180 days	180 days (India only)	180 days	180 days	60 days	180 days

SCHEDULE OF BENEFITS									
Section	**Plans**	**Optima Suraksha**	**Optima Secure**	**Optima Super Secure**	**Optima Secure Global**	**Optima Secure Global Plus**	**Optima Select**	**Optima Lite**	**Optima Secure+**
1.7	Organ Donor Expenses	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured
1.8	Cumulative Bonus	10% of the Basic Sum Insured maximum upto 100% post completion of each policy year irrespective of claims.	Not Covered	Not Covered	Not Covered	Not Covered	25% of the Basic Sum Insured maximum upto 100% post completion of each policy year irrespective of claims	10% of the Basic Sum Insured maximum upto 100% post completion of each policy year irrespective of claims	Not Covered
2.1	Emergency Air Ambulance	Covered Up to 500,000	Covered Up to 500,000	Covered Up to 500,000	Covered Up to 500,000	Covered Up to 500,000	Not Covered	Covered Up to 500,000	Covered Up to 500,000
2.2	Daily Cash for choosing Shared Accommodation	800 per day max up to 4800	800 per day max upto 4800	1000 per day max up to 6000	800 per day max upto 4800 (India only)	800 per day max upto 4800 (India only)	Not Covered	800 per day max upto 4800	800 per day max upto 4800
2.3	Protect Benefit	Not Covered	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Covered upto sum insured	Optional	Optional	Default: Covered upto sum insured Optional: To remove benefit
2.4	Plus Benefit	Not Covered	Bonus of 50% of the Base Sum Insured, maximum upto 100%.	Bonus of 50% of the Base Sum Insured, maximum upto 100%.	Bonus of 50% of the Base Sum Insured, maximum upto 100%.	Bonus of 50% of the Base Sum Insured, maximum upto 100%.	Optional (Bonus of 50% of the Base Sum Insured, maximum upto 100%)	Optional (Bonus of 50% of the Base Sum Insured, maximum upto 100%)	Not Covered
2.5	Secure Benefit	Not Covered	Equal to 100% of Base sum insured	Equal to 200% of Base sum insured	Equal to 100% of Base sum insured (India only)	Equal to 100% of Base sum insured (India only)	Not Covered	Not Covered	Equal to 100% of Base sum insured
2.6	Automatic Restore Benefit	Equal to 100% of Base sum insured	Equal to 100% of Base sum insured	Equal to 100% of Base sum insured	Equal to 100% of Base sum insured (India only)	Equal to 100% of Base sum insured (India only)	Unlimited times	Unlimited times	Unlimited times
2.7	Aggregate Deductible# (Optional)	10K / 25K / 50K / 1L / 2L / 3L / 5L	10K / 25K / 50K / 1L / 2L / 3L / 5L	10K / 25K / 50K / 1L / 2L / 3L / 5L	10K / 25K / 50K / 1L / 2L / 3L / 5L	10K / 25K / 50K / 1L / 2L / 3L / 5L	10K / 25K / 50K / 1L / 2L / 3L / 5L	10K / 25K / 50K	10K/25K/ 50K /1L /2L /3L /5L

SCHEDULE OF BENEFITS									
Section	**Plans**	**Optima Suraksha**	**Optima Secure**	**Optima Super Secure**	**Optima Secure Global**	**Optima Secure Global Plus**	**Optima Select**	**Optima Lite**	**Optima Secure+**
		/ 10L / 20L / 25L	/ 10L / 20L / 25L	/ 10L / 20L / 25L	/ 10L / 20L / 25L (India only)	/ 10L / 20L / 25L (India only)	/ 10L		/10L /20L /25L
2.8	E-Opinion for Critical Illness	In India	In India	Global	Global	Global	Not Covered	In India	In India
2.9	Global Health Cover (Emergency Treatments Only)	Not Covered	Not Covered	Not Covered	Covered (Outside India only)	Not Covered	Not Covered	Not Covered	Not Covered
2.10	Global Health Cover (Emergency & Planned Treatments)	Not Covered	Not Covered	Not Covered	Not Covered	Covered (Outside India only)	Not Covered	Not Covered	Not Covered
2.11	Overseas Travel Secure (Optional)	Not Covered	Not Covered	Not Covered	Covered upto sum insured (Outside India only)	Covered upto sum insured (Outside India only)	Not Covered	Not Covered	Not Covered
2.13	PED wait period modification (Optional)	1 year / 2 year	1 year / 2 year	1 year / 2 year	1 year / 2 year	1 year / 2 year	1 year / 2 year	1 year / 2 year	1 year / 2 year
2.17	Infinite Benefit	Not Covered	Not Covered	Optional (Bonus of 100% of the Base Sum Insured post every policy year)	Not Covered	Not Covered	Not Covered	Not Covered	Bonus of 100% of the Base Sum Insured post every policy year

3	Preventive Health Check-up (India only) [This is an optional cover under Optima Select plan and an inbuilt cover in all other plans]							
	Sum Insured	**5 Lakhs**	**7.5 Lakhs**	**10 Lakhs**	**15 Lakhs**	**20 & 25 Lakhs**	**50 & 75 Lakhs**	**100 & 200 Lakhs**
	Individual Policy**	1,500	1,500	2,000	4,000	5,000	5,000	8,000
	Floater Policy**	2,500	2,500	5,000	8,000	10,000	10,000	15,000

Key to read above table

a. **'Covered'** means that particular benefit is an inbuilt feature in that particular plan- and the premium of such benefits are included in the premium of the respective Plan.

b. **'Not Covered'** means that particular benefit is NOT available either as an inbuilt feature or as an optional feature in that particular plan

c. **'Optional'** means that particular benefit is NOT an inbuilt feature BUT can be opted by the Proposer/Policyholder either at inception or at renewal. However, 'PED wait period modification' optional cover is allowed to be opted at channel level only. Individual customer will not be able to opt for the same.

Notes:

a. Preventive Health Check-up benefit will not be available under the policy if Aggregate Deductible of INR 5 Lakhs is in force.

b. Preventive Health Check-up, Secure Benefit, Cumulative Bonus / Plus Benefit / Infinite Benefit, Automatic Restore Benefit, Daily Cash for Shared Room and Unlimited Restore (Add-on) benefits will not be available under the policy if Aggregate Deductible of INR 10 Lakhs or more is in force.

c. **For Individual policy sum insured and limits mentioned in the table are applicable on per Insured Person per Policy Year basis and for Family Floater policy sum insured and limits apply on per policy per Policy Year basis

d. ^Claims shall be payable as per geography mentioned in the above table unless explicitly stated otherwise in a specific cover.

e. # Aggregate Deductible if opted, shall apply only for claims arising in India. However, a Per Claim Deductible of Rs. 10,000 will apply separately for each and every claim arising out of India in Global plans

f. 5L / 10L Deductible can only be opted with Sum Insured >= 25 L

g. 20L / 25L Deductible can only be opted with Sum Insured >= 50 L

h. Kindly read this document in conjunction with your Policy Schedule for in-depth clarity