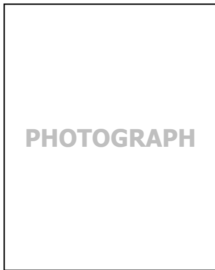
HDFC ERGO General Insurance Company Limited

Proposal Form

my: Optima Secure – Optima Secure Global Plus Plan Proposal Form

Application No: ____



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".

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

Name of the Proposer: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐☐☐☐☐☐☐ Nationality: ☐☐☐☐☐☐☐☐☐

Residential Status: ☐ Resident Indian

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 India

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 ______________________			
BASE SUM INSURED IN ₹				
25 Lakhs ☐	50 Lakhs ☐	75 Lakhs ☐	100 Lakhs ☐	200 Lakhs ☐

OPTIONAL COVERS

S. No.	Optional Cover		Description / Options
1	Overseas Travel Secure	☐	NA
2	PED waiting period modification (allowed to be opted at channel level only)		36 months (default)
			24 months ☐
			12 months ☐
3	Aggregate Deductible	☐	☐ ₹10,000 ☐ ₹25,000 ☐ ₹50,000 ☐ ₹1,00,000 ☐ ₹2,00,000 ☐ ₹3,00,000 ☐ ₹5,00,000 ☐ ₹10,00,000 ☐ ₹20,00,000 [only available with Base SI >= 50 Lac] ☐ ₹25,00,000 [only available with Base SI >= 50 Lac]

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, 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. 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.

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	Individual Personal Accident (IPA) Rider	☐ Yes ☐ No				
3	Unlimited Restore (Add-on)	☐ Yes ☐ No				
4 (a)	my:health Hospital Cash Benefit	☐ Yes ☐ No				
4 (b)	Hospital Cash benefit – Global (Optional cover)	☐ Yes ☐ No				
5	Optima Wellbeing (Add on)	☐ Yes ☐ No				
6	Limitless	☐ Yes ☐ No				
7	Parenthood	☐ ₹ 50K	☐ ₹ 100K	☐ ₹ 150K	☐ ₹ 200K	
8	Serious Illness Booster	☐ Yes ☐ No				

S. No.	Name	IPA Rider Sum Insured in ₹	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. Sum Insured under Individual Personal Accident rider will be 5 (five) times the Sum Insured of my: Optima Secure (Base Plan) up to a maximum of ₹1 Crore and this rider will be offered only to the Proposer when he/she is covered in the Base plan.
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.

OTHER ITEMS

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 (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]**

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]

☐ 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]

☐ 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]

☐ 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]

☐	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 ☐ 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]

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]

☐ 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]

☐ 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:

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 Proposer agrees and undertakes to intimate in writing to HDFC ERGO about any change in bank account details.
2. Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly
3. Name on Cancelled Cheque should match with Proposer Name to ensure smooth refund / claim processing
4. If ECS is selected, please submit the standing instruction form available at our branches.

DECLARATION, CONSENT & WARRANTY ON BEHALF OF ALL PERSON(S) PROPOSED TO BE INSURED

- I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons including the minor/s insured, if any.
- I/ We understand that the information provided by me/ us will form the basis of insurance policy, is subject to the Board approved underwriting policy of the Insurance company and that the policy will come into force only after full receipt to the premium chargeable.
- I/We further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the Insurance Company.
- I/We declare and further consent to the Insurance Company to seek medical and other relevant information from any hospital who at any time has attended the person to be insured/proposer or from any past or present employer concerning anything which affects the physical and mental health of the person to be insured / proposer and seeking information from any insurance company to which an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and /or claim settlement.
- I/ We declare and provide my unconditional consent that, pursuant to a claim filed by me/ us, the Insurance Company can seek medical and other relevant information/ documents for me/ us from any Doctor and/ or Hospital where I, or other Insured, had taken treatment i.e. OPD and/ or hospitalization etc.
- I/We authorize the Insurance Company to share information pertaining to my proposal, including the medical records for the sole purpose of underwriting and/ or claims.
- I/ We authorize the Company to process my/ our Personal information for profiling purposes and contact

me/ us for (i) communicating for renewal of the Policy, (ii) upsell and/ or cross sale of other insurance products.

- I/ We authorize the Insurance Company to share my/ our Personal Information and other relevant records details with (i) the Law Enforcement Agencies, as and when demanded and (ii) any other vendor as per the requirement etc. like printing the Insurance policy/ renewal reminders or any other such activity.
- I/ We authorize the Insurance Company to share my/ our Personal Information and/ or medical Information/ records with any Government and/ or Statutory authorities/ bodies, including but not limited to Insurance Regulatory and Development Authority of India (IRDAI), Insurance Information Bureau (IIB) and/ General Insurance Council etc.
- Customer Satisfaction Surveys: I/ We hereby consent to the Insurance Company to use and share my/ our Personal Information with the vendors for the purpose of conducting customer satisfaction surveys and related activities aimed at improving service quality and enhancing the overall customer experience.
- Ayushman Bharat Health Account (ABHA) Declaration : I/We provide my/ our consent to access my/ our (all insured) medical and personal records/ details, as are available in my/ our Ayushman Bharat Health Account (ABHA) and share the same with Third Party Administrators, Reinsurer (if applicable), Service Provider/s of HDFC ERGO and/or with any Governmental and/or Regulatory authority for the sole purposes of underwriting my/ our proposal and/ or for checking the authenticity of claims lodged by me/ us and/ or to comply with the applicable Law/ Regulations.
- I/We hereby consent that, in any of the above scenarios, my/ our Personal Information and the medical documents etc. can be shared, and/ or accessed, as the case may be, without any intimation to me/ us.
- I hereby grant consent to Agent/Broker/Corporate Agent or any other licensed intermediary to share my KYC (Know your Customer) and customer due diligence information with HDFC ERGO General Insurance Company Limited for the purpose of my insurance proposal.

Signature of the Proposer: ________________________________ Date : __________________

Time: __________________ Place : __________________

Note: The liability of the company does not commence until the acceptance of the proposal has been formally intimated by the insured and full premium has been realized by the company.

We are under no obligation to accept any proposal for insurance. The Proposer agrees that the receipt of the Proposal Form by HDFC ERGO General Insurance Company Limited along with the premium payment does not tantamount to the acceptance of the Proposal for insurance by HDFC ERGO General Insurance Company Limited and does not result in a concluded contract of insurance. The acceptance of the Proposal for insurance shall be at the Company's sole and absolute discretion and upon full realization of the premium payment. In the event of acceptance of the Proposal for insurance by HDFC ERGO General Insurance Company Limited, such acceptance shall be specifically intimated to the Proposer by HDFC ERGO General Insurance Company Limited along with the date from which the insurance Cover shall become effective. HDFC ERGO General Insurance Company Limited shall not be liable for any claim in respect of an event giving rise to a claim covered under the Policy of Insurance that has occurred prior to policy issuance is not covered under this policy (Your proposal form will be considered after HDFCERGO General Insurance Company Limited receives premium payment.)

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 Proposer: ____________________

Place: ____________________ ____________________

Date: ____________________ Signature of the Proposer

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.