



**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  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): \_\_\_\_\_

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>

HDFC ERGO General Insurance Company Limited. IRDAI Reg. No. 146 CIN: U66030MH2007PLC177117. Registered & Corporate Office: 6th Floor, Leela Business Park, Andheri-Kurla Road, Andheri (East), Mumbai – 400 059. Product Name: my: Optima Secure: Product UIN: HDFHLIP26058V082526 | Product code: HE/RL/Health/25-26/280 | my: health Critical Illness - HDFHLIA22141V032122 | my: Health Hospital Cash Benefit (Add-on) - HDFHLIA21271V022021 | Unlimited Restore (Add On) HDFHLIA2760V022627 | IPA Rider – APOPAIP19004V011920 | Limitless - HDFHLIA2761V022627 | ABCD Chronic Care – HDFHLIA25044V012425 | Parenthood - HDFHLIA25046V012425 | Optima Wellbeing (Add-on) -HDFHLIA2762V022627 | Serious Illness Booster – HDFHLIA26059V012526

**PREMIUM TIER (PLEASE TICK)**

<b>Tier 1</b> <input type="checkbox"/>	<b>Tier 2</b> <input type="checkbox"/>	<b>Tier 3</b> <input type="checkbox"/>	<b>Tier 4</b> <input type="checkbox"/>	<b>Tier 5</b> <input type="checkbox"/>	<b>Tier 6</b> <input type="checkbox"/>
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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**

<b>Policy Type</b>	Individual <input type="checkbox"/> Family <input type="checkbox"/> Floater <input type="checkbox"/>
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<b>Tenure</b>	1 Year <input type="checkbox"/> 2 Year <input type="checkbox"/> 3 Year <input type="checkbox"/> 4 Year <input type="checkbox"/> 5 Year <input type="checkbox"/>
<b>Policy Period</b>	From _____ To _____
<b>BASE SUM INSURED IN ₹</b>	
5 Lakhs <input type="checkbox"/>	10 Lakhs <input type="checkbox"/>
20 Lakhs <input type="checkbox"/>	50 Lakhs <input type="checkbox"/>

**OPTIONAL COVERS**

S. No.	Optional Cover	Description / Options
1	PED waiting period modification (allowed to be opted at channel level only)	36 months (default) 24 months <input type="checkbox"/> 12 months <input type="checkbox"/>
2	Aggregate Deductible	<input type="checkbox"/> ₹10,000 <input type="checkbox"/> ₹25,000 <input type="checkbox"/> ₹50,000 <input type="checkbox"/> ₹1,00,000 <input type="checkbox"/> ₹2,00,000 <input type="checkbox"/> ₹3,00,000 <input type="checkbox"/> ₹5,00,000 <input type="checkbox"/> ₹10,00,000 <input type="checkbox"/> ₹20,00,000 <input type="checkbox"/> ₹25,00,000

**Note:**

- Preventive health check-up benefit will not be available under the policy if Aggregate Deductible of INR 5 Lakhs is in force.
- 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.
- 5L / 10L Deductible can only be opted with Base Sum Insured >= 25 L
- 20L / 25L Deductible can only be opted with Base Sum Insured >= 50 L
- 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)	<input type="checkbox"/> <b>Plan 1</b> (9 Illnesses)	<input type="checkbox"/> <b>Plan 2</b> (12 Illnesses)	<input type="checkbox"/> <b>Plan 3</b> (15 Illnesses)	<input type="checkbox"/> <b>Plan 4</b> (18 Illnesses)
		<input type="checkbox"/> <b>Plan 5</b> (25 Illnesses)	<input type="checkbox"/> <b>Plan 6</b> (40 Illnesses)	<input type="checkbox"/> <b>Plan 7</b> (51 Illnesses)	
2	Individual Personal Accident (IPA) Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No			
3	Unlimited Restore (Add-on)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
4 (a)	my:health Hospital Cash Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No			
4 (b)	Hospital Cash benefit – Global (Optional cover)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5	Optima Wellbeing (Add on)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6	Limitless	<input type="checkbox"/> Yes <input type="checkbox"/> No			
7	Parenthood	<input type="checkbox"/> ₹ 50K	<input type="checkbox"/> ₹ 100K	<input type="checkbox"/> ₹ 150K	<input type="checkbox"/> ₹ 200K
8	Serious Illness Booster	<input type="checkbox"/> Yes <input type="checkbox"/> 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			<input type="checkbox"/>								
2			<input type="checkbox"/>								
3			<input type="checkbox"/>								
4			<input type="checkbox"/>								
5			<input type="checkbox"/>								
6			<input type="checkbox"/>								

### 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.

## 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](http://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		Sum Insured	Claims lodged during the preceding years(Y/N)	To be considered for continuity (Y/N)
			DD/MM/YYYY	To DD/MM/YYYY			

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>

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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

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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

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

Please share your expected delivery date with us

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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 is 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: \_\_\_\_\_

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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>

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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>

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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 is 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 is opted]

- |                          |                    |   |
|--------------------------|--------------------|---|
| <input type="checkbox"/> | Cigarette(s)       | Per Day_____Per Week_____Per Month_____since past _____ years |
| <input type="checkbox"/> | Bidi(s)            | Per Day_____Per Week_____Per Month_____since past _____ years |
| <input type="checkbox"/> | Tobacco Pouches    | Per Day_____Per Week_____Per Month_____since past _____ years |
| <input type="checkbox"/> | Gutka Pouches      | Per Day_____Per Week_____Per Month_____since past _____ years |
| <input type="checkbox"/> | Alcohol (Quantity) | Per Day_____Per Week_____Per Month_____since past _____ years |
| <input type="checkbox"/> | 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>

- Has an ailment or disability or deformity including due to accident or congenital disease  Yes  No
- Has planned a surgery  Yes  No
- Takes medicines regularly  Yes  No
- Has been advised investigation or further tests  Yes  No
- Was hospitalized in the past  Yes  No
- Is Pregnant  Yes  No  
(Applicable for females >=18 years and <=55 years.)
- 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 is opted]**

<input type="checkbox"/> Cigarette(s)	Per Day_____Per Week_____Per Month_____since past _____ years
<input type="checkbox"/> Bidi(s)	Per Day_____Per Week_____Per Month_____since past _____ years
<input type="checkbox"/> Tobacco Pouches	Per Day_____Per Week_____Per Month_____since past _____ years
<input type="checkbox"/> Gutka Pouches	Per Day_____Per Week_____Per Month_____since past _____ years
<input type="checkbox"/> Alcohol (Quantity)	Per Day_____Per Week_____Per Month_____since past _____ years
<input type="checkbox"/> 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

HDFC ERGO General Insurance Company Limited. IRDAI Reg. No. 146 CIN: U66030MH2007PLC177117. Registered & Corporate Office: 6th Floor, Leela Business Park, Andheri-Kurla Road, Andheri (East), Mumbai – 400 059. Product Name: my: Optima Secure: Product UIN: HDFHLIP26058V082526 | Product code: HE/RL/Health/25-26/280 | my: health Critical Illness - HDFHLIA22141V032122 | my: Health Hospital Cash Benefit (Add-on) - HDFHLIA21271V022021 | Unlimited Restore (Add On) HDFHLIA2760V022627 | IPA Rider – APOPAIP19004V011920 | Limitless - HDFHLIA2761V022627 | ABCD Chronic Care – HDFHLIA25044V012425 | Parenthood - HDFHLIA25046V012425 | Optima Wellbeing (Add-on) -HDFHLIA2762V022627 | Serious Illness Booster – HDFHLIA26059V012526

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]

**[TO BE FILLED ONLY IF my: health Critical Illness is opted]**

<input type="checkbox"/>	Cigarette(s)	Per Day_____Per Week_____Per Month_____since past _____ years
<input type="checkbox"/>	Bidi(s)	Per Day_____Per Week_____Per Month_____since past _____ years
<input type="checkbox"/>	Tobacco Pouches	Per Day_____Per Week_____Per Month_____since past _____ years
<input type="checkbox"/>	Gutka Pouches	Per Day_____Per Week_____Per Month_____since past _____ years
<input type="checkbox"/>	Alcohol (Quantity)	Per Day_____Per Week_____Per Month_____since past _____ years
<input type="checkbox"/>	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>

- Has an ailment or disability or deformity including due to accident or congenital disease  Yes  No
- Has planned a surgery  Yes  No
- Takes medicines regularly  Yes  No
- Has been advised investigation or further tests  Yes  No
- Was hospitalized in the past  Yes  No
- Is Pregnant  Yes  No  
(Applicable for females >=18 years and <=55 years.)
- 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

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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 is 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 Bima-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 misrepresentation, 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 Section 41 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.

HDFC ERGO General Insurance Company Limited. IRDAI Reg. No. 146 CIN: U66030MH2007PLC177117. Registered & Corporate Office: 6th Floor, Leela Business Park, Andheri-Kurla Road, Andheri (East), Mumbai – 400 059. Product Name: my: Optima Secure: Product UIN: HDFHLIP26058V082526 | Product code: HE/RL/Health/25-26/280 | my: health Critical Illness - HDFHLIA22141V032122 | my: Health Hospital Cash Benefit (Add-on) - HDFHLIA21271V022021 | Unlimited Restore (Add On) HDFHLIA2760V022627 | IPA Rider – APOPAIP19004V011920 | Limitless - HDFHLIA2761V022627 | ABCD Chronic Care – HDFHLIA25044V012425 | Parenthood - HDFHLIA25046V012425 | Optima Wellbeing (Add-on) -HDFHLIA2762V022627 | Serious Illness Booster – HDFHLIA26059V012526