HDFC ERGO General Insurance Company Limited

Health Suraksha - Proposal Form

(All fields are mandatory and fill in CAPITALS only)

Application No.: _____

PROPOSER DETAILS

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

Address

District City Pin Code

State Mobile

Tel.(Res.) STD Code (Off.) STD Code

Email

Nationality Marital Status: Married ☐ Unmarried ☐ Annual Income

Profession: Salaried ☐ Self Employed ☐ Others ☐ Details: _____

ID Proof Type: PAN ☐ Passport ☐ Driving License ☐ Voters Card ☐ If others please specify: _____

ID Proof No.: PAN No.: eIA No.: Aadhar Card:

DETAILS OF THE PERSON PROPOSED TO BE INSURED

S.No.	Name of the Insured person	Height	Weight	Relationship to Policyholder	Gender*	Date of Birth	Occupation (Designation/ Exact nature of duties)	Sum Insured**	Critical Illness Sum Insured***
1.		(cms)	(kg)		M / F	D D M M Y Y Y Y			
2.		(cms)	(kg)		M / F	D D M M Y Y Y Y			
3.		(cms)	(kg)		M / F	D D M M Y Y Y Y			
4.		(cms)	(kg)		M / F	D D M M Y Y Y Y			
5.		(cms)	(kg)		M / F	D D M M Y Y Y Y			
6.		(cms)	(kg)		M / F	D D M M Y Y Y Y			

* Gender Code M (Male), F(Female) ** Family Floater policy will have same Sum Insured for all members (See brochure for floater policy details) ***Critical Illness Sum Insured would be 50% or 100% of the Sum Insured and the same rule is applicable to all members.

PHOTOGRAPHS [If available]

Please paste the photographs in sequence [Insured 1, Insured 2, Insured 3, Insured 4, Insured 5 and Insured 6] as specified in section 3 of details of proposed to be insured

Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6

NOMINEE DETAILS

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. Nominee for any of the persons proposed to be insured shall be the Proposer.

Nominee Name	Relationship	Address of Nominee

*If the Nominee is minor, Name and Address of Appointee and Relationship with Minor:

Appointee Name	Relationship	Address of Appointee

PLAN DETAILS

Plan Name: ☐ Silver ☐ Gold ☐ Platinum Type: ☐ Individual ☐ Family Floater* Policy Period: ☐ 1 Year ☐ 2 Year

Proposed Policy Period: From D D M M Y Y Y Y To D D M M Y Y Y Y

Optional Benefits (at additional premium) Please tick the benefits to be opted

☐ Regain Benefit ☐ Enhancement of Cumulative Bonus

For complete list of optional Benefits, please refer page No. 4

EXISTING/PREVIOUS INSURANCE DETAILS*

Is the proposer or the persons proposed, already insured under a plan with HDFC ERGO Health Insurance Company Limited or any other insurance company? If yes, please indicate below the Policy/ Application number(s) (Please mention application number incase of pending proposal.)
Since when are continuously insured: Do you want Us to consider these details for continuity* ? Yes ☐ No ☐

Policy No. / Application No.	Insurer	Period of Insurance		Sum Insured (₹)	Claims lodged during the preceding years
		From	To		
		D D M M Y Y Y Y	D D M M Y Y Y Y		
		D D M M Y Y Y Y	D D M M Y Y Y Y		
		D D M M Y Y Y Y	D D M M Y Y Y Y		
		D D M M Y Y Y Y	D D M M Y Y Y Y		

* 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 and relevant supporting documents are not submitted.

MEDICAL AND LIFE STYLE INFORMATION

Medical History: Please answer the below mentioned questions in Yes(Y) / No (N)

Section A: Has any of the person proposed to be insured ever suffered from/ are currently suffering from any of the following:	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
I. High or low blood pressure, Chest Pain, or any other cardiac disorder?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
II. Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
III. Ulcer(Stomach/Duodenal),liver or gall bladder disorder or any other digestive tract disorder?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
IV. Kidney Failure, Stone in kidney or urinary tract, Prostate disorder or any other kidney/urinary tract disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
V. Stroke, Epilepsy (fits), Paralysis or any other nervous system (Brain, Spinal cord, etc) disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
VI. Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
VII. Tumor (Swelling)-benign or malignant, any external ulcer/growth/cyst/mass anywhere in the body?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
VIII. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
IX. Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error) ?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
X. HIV/AIDS or sexually transmitted diseases or any immune system disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
XI. Anaemia, Leukaemia, Lymphoma or any other blood/lymphatic system disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
XII. Psychiatric/ Mental illnesses or sleep disorder	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
XIII. Uterine Fibroid, Fibroadenoma breast or any other Gynaecological(Female reproductive system)/Breast disorder?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Section B: Has any of the persons proposed to be insured?	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
XIV. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
XV. Been under any regular medication (self/ prescribed)?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
XVI. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
XVII. Undertaken any surgery or a surgery been advised and have surgery still pending?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
XVIII. Suffered from any other disease/illness/accident/injury other than common cold or viral fever?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
XIX. Is any of the insured pregnant? If yes please mention the expected date of delivery	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
XX. Any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Section C: Name and details of Illness/ Medicine/Test/ Surgery/ Diopter grade (for questions answered as Yes in Section A & B above)	Exact diagnosis	Diagnosis date	Date of last consultation	Treatment in/outpatient and details of treatment given	Doctor/Hospital Name and Phone No.
Insured 1					
Insured 2					
Insured 3					
Insured 4					
Insured 5					
Insured 6					

Section D: Name, address, qualification and contact details of the family doctor

Name (First Name) (Middle Name) (Last Name)

Address

Qualification Phone Number Mobile Number

Email

Section E: Does any person proposed to be insured smoke or consume gutkha/pan masala or alcohol. If yes please indicate the name and quantity per week.	Alcohol	Smoke	Pan Masala	Others
Insured 1				
Insured 2				
Insured 3				
Insured 4				
Insured 5				
Insured 6				

Section F: In respect of any of the persons proposed to be insured:	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Has any application for life, health, hospital daily cash or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

PAYMENT DETAILS

Please fill in your payment details for either Cheque/Credit Card option

Cheque No. Bank Name

Branch City

Dated D D M M Y Y Y Y For (Rs.) Credit Card No.

Credit Card: Master ☐ Visa ☐ Expiry Date D D M M Y Y Y Y Relationship to the Policyholder

Card Holders Name Mr./ Ms./ Mrs. (If different from insured) (First Name) (Middle Name) (Last Name)

PREMIUM DETAILS

Amount Rs. Rupees

BANK A/C DETAILS (Required For Refunds If Any/Claims)

Would you like your refund (Excess Premium/PPC reimbursement) ☐ By Cheque* or ☐ Credited directly into your bank account.(Tick as applicable)
* Cheque will be issued in the name of the Proposer only.

In case of payment made through credit card the refund amount would be reversed in Credit Card account directly or through cheque.
Please provide the following bank details and a copy of a Cancelled Cheque if you opt for direct credit into your bank account:
(Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly)

Name as in Bank Account (First Name) (Middle Name) (Last Name)

Bank Name Bank Branch

Bank Account number IFSC Code MICR No.

Note: The Proposer agrees and undertakes to intimate in writing to HDFC ERGO about any change in bank account details. Date D D M M Y Y Y Y

GENERAL EXCLUSIONS (Under the Policy) For more details please refer to the Policy Wordings

The following is an outline of the general exclusions under the policy. For more details on the exclusions and the waiting periods please refer to the policy wordings before purchasing this policy.

Waiting Periods - 30 days waiting period in the first year and is not applicable in subsequent renewals. 2 years waiting period for the specified illnesses/ surgeries. 4 years waiting period for Pre-existing conditions. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. Any Insured Person committing or attempting to commit a breach of law with criminal intent, or intentional self injury or attempted suicide while sane or insane. Any Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing. Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies. Treatment of Obesity and any weight control program. Plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, Cancer or Burns. Treatment for correction of eye due to refractive error. Circumcisions (unless necessitated by illness or injury and forming part of treatment); Aesthetic or change-of-life treatments of any description such as sex transformation operations, treatments to do or undo changes in appearance driven by cultural habits, fashion or the like or any procedures which improve physical appearance. Save as and to the extent provided for under Ayush Benefit), Non allopathic treatment. Conditions for which Hospitalization is not required. Experimental, investigational or unproven treatment devices and pharmacological regimens. Admission primarily for diagnostic purposes not related to Illness for which Hospitalization has been done. . Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing. Enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. Save as and to the extent provided for under Benefit Spectacles, Contact lenses & Hearing Aids Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products. Artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively). Psychiatric, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), sleep-apnoea. Congenital internal or external diseases, defects or anomalies, genetic disorders. Stem cell therapy or surgery, or growth hormone therapy. Venereal disease, sexually transmitted disease or illness; "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis. Save as and to the extent provided for under Maternity Benefit, Pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy in relation to in-patient only. Sterility, treatment whether to effect or to treat infertility, any fertility, sub-fertility or assisted conception procedure, surrogate or vicarious pregnancy, birth control, contraceptive supplies or services including complications arising due to supplying services. Expenses for organ donor screening, or save as and to the extent provided for in Organ Donor Benefit-Organ Donor, the treatment of the donor (including surgery to remove organs from a donor in the case of transplant surgery). Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities. Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls (wherever specifically charged for), foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies. vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. Treatments rendered by a Medical Practitioner who is a member of the insured's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments which are not supported by a prescription. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing. Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured, as per Our underwriting guidelines.

DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- I/We hereby declare on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.
- I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved underwriting policy of the Insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- I/We further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- I/we declare and further consent to the company. seeking medical information from any hospital Iwho at anytime has attended on the life to be insured/ proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/ proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory Authority.

INSURER`S DECLARATION

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

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

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

Fraud Warning: This policy shall be voidable at the option of the Company in the event of mis-representation, mis-description or non-disclosure of any material particulars by the Proposer.
Any person who, knowingly and with intent to defraud the insurance company or any other person, files a proposal for insurance containing any false information, or conceals for the purpose of misleading, Information 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 of 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. Violations of Section 41 of the Insurance Act 1938, as amended, shall be punishable with a fine which may extend to five hundred (500) Rupees.

Place

Date D D M M Y Y Y Y

Signature of the Proposer

VERNACULAR DECLARATION

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent/employee of the company):

Name of Proposer

The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same.

Place

Date D D M M Y Y Y Y

Signature of the Proposer

Name of the witness

Signature of the witness

AGENT'S DECLARATION

I,_____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised 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 herein 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 favour 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.

License No.(Advisor/Corporate Agent/Broker/Relationship Officer)

Place

Date D D M M Y Y Y Y

Signature of Agent

CHECKLIST

Please check the following documents are attached along with the proposal form

i. ID Proof: Passport/ Pan Card/Voter id card/Driving License/ Letter from a recognized public authority
ii. Proof of residence: Telephone Bill/ Bank Account Statement/ letter from any recognized public authority/Electricity Bill/ Ration Card
iii. Age Proof: Proof of Age
iv. Renewal Notice with claim details
v. Photocopies of all previous policies and endorsements

FOR OFFICE USE ONLY

Channel Partner Code

Branch Location

Signature of Channel Partner

Insurance is the subject matter of solicitation

ACKNOWLEDGMENT - CUSTOMER COPY

Received from Mr. / Mrs. / Ms. _____ Cheque No. _____

Dated _____ Drawn on _____ Bank for a sum of Rs. _____

towards payment of premium on behalf of HDFC ERGO General Insurance Company Ltd.

Date D D M M Y Y Y Y

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 30 days.

Optional Benefits (at additional premium) Please tick the benefits to be opted

Silver Plan		
Sr. No.	**Optional Benefits (on payment of additional premium)**	**Selection**
1.	Co-payment option 10%	
2.	Co-payment option 20%	
3.	Critical Illness upto 50% of SI	
4.	Critical Illness upto 100% of SI	
5.	Hospital Daily Cash for 30 days	
6.	Hospital Daily Cash for 60 days	
7.	Convalescence benefit	
8.	E-Opinion for Critical Illness	
9.	Maternity Sum Insured of Rs.25,000	
10.	Maternity Sum insured of Rs.40,000	
11.	Dental Cover	
12.	Spectacles/Contact Lenses and/or Hearing Aid	

Gold/ Platinum Plan		
Sr. No.	**Optional Benefits (on payment of additional premium)**	**Selection**
1.	Co-payment option 10%	
2.	Co-payment option 20%	
3.	Critical Illness upto 50% of SI	
4.	Critical Illness upto 100% of SI	
5.	Hospital Daily Cash for 30 days	
6.	Hospital Daily Cash for 60 days	

Hospital Daily Cash Sum Insured Option (in Rs.): 500 ☐ 1000 ☐ 1500 ☐ 2000 ☐ 2500 ☐