# HDFC ERGO General Insurance Company Limited

## Proposal Form

## Optima Restore

Photograph

**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".
3. 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** D D M M Y Y Y Y **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** ☐ Y ☐ N

**Contact Number** **Permanent Account Number (PAN)**

**I have eIA** ☐ Y ☐ N

**I would like to apply for eIA** ☐ Karvy ☐ CAMS ☐ NSDL ☐ CDSL

**Annual Income** ☐ Upto 2.5 Lac ☐ 2.5 Lac to 5 Lac ☐ 5 Lac to 15 Lac ☐ 15 Lac to 30 Lac ☐ Above 30 Lac

**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** | ☐ Y | ☐ N |
| *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<br>☐ Student ☐ Housewife ☐ Retired<br>☐ Others _____ | |
| | If others, please select source of income whichever is applicable:<br>☐ Rentals ☐ Interest<br>☐ Pension ☐ Investment | |
| **Industry Type** | ☐ Antique dealer ☐ Art dealer ☐ Jewellery<br>☐ Import-Export ☐ Mining ☐ Shipping<br>☐ Scrap Dealing ☐ Agriculture ☐ Stock Broking<br>☐ BFSI ☐ Real Estate ☐ Manufacturing<br>☐ if Others, please specify _____ | |
| Is your total aggregate premium across all products with HDFC ERGO General Insurance Company Limited more than INR 2 lakhs? | ☐ Y | ☐ N |
| Do you have investable assets for more than INR 5 crores? *(Investable assets like cash holdings, deposits, stocks and bonds etc.)* | ☐ Y | ☐ N |
| Is your total aggregate premium across all retail products with HDFC ERGO General Insurance Company Limited INR 5 lakhs or more? | ☐ Y | ☐ N |

## DETAILS OF THE PERSON(S) PROPOSED TO BE INSURED

| S. No | Name | Basic Sum Insured | Date of Birth | Mobile Number | Gender (M/F/TG) | Height (in cms) | Weight (in kgs) | Relationship with Proposer | Politically Exposed person (Y / N) | 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 ☐ |
|---|---|

Classification of Cities for Premium Tier

- Tier 1: Delhi, National Capital Region (NCR), Mumbai, Mumbai Suburban, Thane and Navi Mumbai, Surat, Ahmedabad and Vadodara.
- Tier 2: Rest of India

No co-payment shall apply if Insured Person from Tier 2 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 ☐ |
| **Policy Period** | From ☐☐☐☐☐☐☐☐☐☐ |
| | To ☐☐☐☐☐☐☐☐☐☐ |

## SUM INSURED IN ₹

| | | | |
|---|---|---|---|
| 3 Lakhs ☐ | 5 Lakhs ☐ | 10 Lakhs ☐ | 15 Lakhs ☐ |
| 20 Lakhs ☐ | 25 Lakhs ☐ | 50 Lakhs ☐ | 100 Lakhs ☐ |

## OPTIONAL COVERS

| S. No. | Optional Cover | | Description |
|---|---|---|---|
| 1 | Unlimited Restore Benefit | ☐ | Unlimited restorations in a policy year |
| 2 | Aggregate Deductible | ☐ | ☐ Rs. 25,000<br>☐ Rs. 50,000<br>☐ Rs. 1,00,000 |
| 3 | Co-payment | ☐ | ☐ 10 % ☐ 20 % |

**Notes pertaining to optional covers**

a. Coverage for Unlimited Restore benefit and 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.

b. Co-payment shall be applicable on per claim basis

c. Aggregate deductible can be chosen on all or none basis at policy level

d. Co-pay can be chosen on all or none basis at policy level

## ADD-ON COVERS

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | my: health Critical Illness<br>(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 Rider | ☐ | Yes | | | |
| 3 | Protector Rider | ☐ | Yes | | | |
| 4 | Hospital Daily Cash Rider<br>(Maximum upto 30 days) | ☐ | ☐ ₹ 1,000 / day | ☐ ₹ 2,000 / day | ☐ ₹ 3,000 / day | |

| | | | |
|---|---|---|---|
| 5 | Critical Advantage Rider | ☐ | ☐ USD 2,50,000 ☐ USD 5,00,000 |
| 6 | Optima Wellbeing (Add on) | ☐ | Yes |
| 7 | Limitless | ☐ | Yes |
| 8 | Parenthood | ☐ | ☐ ₹ 50 K ☐ ₹ 100 K ☐ ₹ 150 K ☐ ₹ 200 K |

Add-on cover details table

| S. No | Name | my: health Critical Illness Sum Insured (INR) | Hospital Daily Cash Rider per day Sum Insured (INR) | Protector Rider (Yes/No) | IPA Rider Sum Insured (INR) | Critical Advantage Rider Sum insured (USD) | Optima Wellbeing (Add on) (Yes/No) | ABCD Chronic Care (if opted kindly tick below) |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | ☐ |
| 2 | | | | | | | | ☐ |
| 3 | | | | | | | | ☐ |
| 4 | | | | | | | | ☐ |
| 5 | | | | | | | | ☐ |
| 6 | | | | | | | | ☐ |

**Notes pertaining to Add-on covers**

a. Coverage for 'my:health Critical Illness', 'Individual Personal Accident Rider', 'Critical Advantage Rider' shall be on Individual Sum Insured basis only.

b. Coverage for Protector Rider, Hospital Daily cash Rider 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.

c. 'my: health Critical Illness' can be opted by adults (persons over 18 years of age) only

d. 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.

e. Critical advantage rider will be offered only if base policy Sum Insured is ₹ 10 lacs & above. This rider can be opted by adult dependent only if primary insured also opts for the same. Incase of dependent children and dependent parents rider can be opted on all or none basis.

f. Sum Insured under Individual Personal Accident rider will be 5 (five) times the Sum Insured of Optima Restore (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.

g. 'Parenthood' can be opted if at least 1 female of 18 year or above is insured under the Base plan.

## 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.

## MEDICAL AND LIFESTYLE INFORMATION
**(Please provide information in the same order as mentioned under Proposed Persons to be insured)**

### MEDICAL & LIFESTYLE QUESTIONS FOR PERSON PROPOSED TO BE INSURED
[TO BE REPEATED FOR EACH PERSON PROPOSED TO BE INSURED]
**INSURED 1**

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

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

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

1. Has an ailment or disability or deformity ☐ Yes ☐ No. If Yes, please provide the below details

   Please tick additional information about your ailment for

   ☐ Hypertension/ High blood pressure

- ☐ Diabetes/ High blood sugar/Sugar in urine
- ☐ Cancer, Tumour, Growth or Cyst of any kind
- ☐ Chest Pain/ Heart Attack or any other Heart Disease/ Problem
- ☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
- ☐ Kidney ailment or Diseases of Reproductive organs
- ☐ Tuberculosis/ Asthma or any other Lung disorder
- ☐ Ulcer (Stomach/ Duodenal), or any ailment of Digestive System
- ☐ Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Nervous, Psychiatric or Mental or Sleep disorder
- ☐ Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage
- ☐ Any other disease/condition not mentioned above

(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure

Exact Diagnosis:

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

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ No (If answer is 'No', below question is mandatory)

Question: Have you stopped medication on Doctor's advice? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date _____

(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine

Exact Diagnosis: ☐ Type 1 DM/IDDM ☐ Type 2 DM ☐ GDM (Gestational Diabetes)

Are you taking insulin? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date: _____

(iii) Please share details for your ailment (except for Diabetes and Hypertension)

Exact Diagnosis: _____

Diagnosis Date: _____

Treatment type: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

Current status: ☐ Pending Treatment ☐ Ongoing Treatment ☐ Cured

☐ If others, please specify _____

Biopsy report: ☐ Malignant ☐ Non-Malignant ☐ Not Applicable

Consultation Date: _____

Hospital Name: _____

Please share details of your treatment:

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

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

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

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

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

Please share details for your current medication <name of the person proposed to be insured>

(i) If exact diagnosis is Hypertension then please provide details of the below questions

Exact Diagnosis: _____

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

Diagnosis Date: _____ Consultation Date: _____

(ii) If exact diagnosis is Diabetes then please provide details of the below questions

Exact Diagnosis: _____

Takes insulin ☐ Yes ☐ No

Diagnosis Date: _____ Consultation Date: _____

(iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Medicine Name: _____

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

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

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

Date of tests: _____

Type of tests: _____

Findings of tests: _____

Please upload the investigation tests results

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

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

Exact Diagnosis: _____ Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Please share details of your past medical condition

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

Please share your expected delivery date with us

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

If Yes, Kindly tick the specific boxes that are applicable:

- ☐ Amputation
- ☐ Musculoskeletal / Locomotor
- ☐ Neurological / Cerebral Palsy
- ☐ Polio
- ☐ Spinal cord
- ☐ Stroke
- ☐ Visual / Hearing disability
- ☐ Others

Kindly provide a detailed description for all boxes ticked above: _____

**LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]**

[TO BE FILLED ONLY IF my: health Critical Illness or Her Horizon or both add-on/s is /are opted]

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Cigarette(s) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Bidi(s) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Tobacco Pouches | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Gutka Pouches | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Alcohol (Quantity) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Drugs_(Quantity) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |

## MEDICAL 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 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]

1. Has an ailment or disability or deformity ☐ Yes ☐ No. If Yes, please provide the below details

Please tick additional information about your ailment for

- ☐ Hypertension/ High blood pressure
- ☐ Diabetes/ High blood sugar/Sugar in urine
- ☐ Cancer, Tumour, Growth or Cyst of any kind
- ☐ Chest Pain/ Heart Attack or any other Heart Disease/ Problem

- ☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
- ☐ Kidney ailment or Diseases of Reproductive organs
- ☐ Tuberculosis/ Asthma or any other Lung disorder
- ☐ Ulcer (Stomach/ Duodenal), or any ailment of Digestive System
- ☐ Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Nervous, Psychiatric or Mental or Sleep disorder
- ☐ Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage
- ☐ Any other disease/condition not mentioned above

(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure

Exact Diagnosis:

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

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ No (If answer is 'No', below question is mandatory)

Question: Have you stopped medication on Doctor's advice? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date _____

(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine

Exact Diagnosis: ☐ Type 1 DM/IDDM ☐ Type 2 DM ☐ GDM (Gestational Diabetes)

Are you taking insulin? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date: _____

(iii) Please share details for your ailment (except for Diabetes and Hypertension)

Exact Diagnosis: _____

Diagnosis Date: _____

Treatment type: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

Current status: ☐ Pending Treatment ☐ Ongoing Treatment ☐ Cured

☐ If others, please specify _____

Biopsy report: ☐ Malignant ☐ Non-Malignant ☐ Not Applicable

Consultation Date: _____

Hospital Name: _____

Please share details of your treatment:

_____

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

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

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

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

---

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

Please share details for your current medication <name of the person proposed to be insured>

(i) If exact diagnosis is Hypertension then please provide details of the below questions

Exact Diagnosis: _____

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

Diagnosis Date: _____ Consultation Date: _____

(ii) If exact diagnosis is Diabetes then please provide details of the below questions

Exact Diagnosis: _____

Takes insulin ☐ Yes ☐ No

Diagnosis Date: _____ Consultation Date: _____

(iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Medicine Name: _____

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

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

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

Date of tests: _____

Type of tests: _____

Findings of tests: _____

Please upload the investigation tests results

---

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

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

Exact Diagnosis: _____ Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Please share details of your past medical condition

---

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

Please share your expected delivery date with us

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

If Yes, Kindly tick the specific boxes that are applicable:

- ☐ Amputation
- ☐ Musculoskeletal / Locomotor
- ☐ Neurological / Cerebral Palsy
- ☐ Polio
- ☐ Spinal cord
- ☐ Stroke
- ☐ Visual / Hearing disability
- ☐ Others

Kindly provide a detailed description for all boxes ticked above: _____

**LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]**

[TO BE FILLED ONLY IF my: health Critical Illness or Her Horizon or both add-on/s is /are opted]

| | | | | | |
|---|---|---|---|---|---|
| ☐ Cigarette(s) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ | years |
| ☐ Bidi(s) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ | years |
| ☐ Tobacco Pouches | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ | years |
| ☐ Gutka Pouches | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ | years |
| ☐ Alcohol (Quantity) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ | years |
| ☐ Drugs_(Quantity) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ | years |

## MEDICAL 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 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]

1. Has an ailment or disability or deformity ☐ Yes ☐ No. If Yes, please provide the below details

Please tick additional information about your ailment for

- ☐ Hypertension/ High blood pressure
- ☐ Diabetes/ High blood sugar/Sugar in urine
- ☐ Cancer, Tumour, Growth or Cyst of any kind
- ☐ Chest Pain/ Heart Attack or any other Heart Disease/ Problem

- ☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
- ☐ Kidney ailment or Diseases of Reproductive organs
- ☐ Tuberculosis/ Asthma or any other Lung disorder
- ☐ Ulcer (Stomach/ Duodenal), or any ailment of Digestive System
- ☐ Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Nervous, Psychiatric or Mental or Sleep disorder
- ☐ Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage
- ☐ Any other disease/condition not mentioned above

(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure

Exact Diagnosis:

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

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ No (If answer is 'No', below question is mandatory)

Question: Have you stopped medication on Doctor's advice? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date _____

(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine

Exact Diagnosis: ☐ Type 1 DM/IDDM ☐ Type 2 DM ☐ GDM (Gestational Diabetes)

Are you taking insulin? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date: _____

(iii) Please share details for your ailment (except for Diabetes and Hypertension)

Exact Diagnosis: _____

Diagnosis Date: _____

Treatment type: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

Current status: ☐ Pending Treatment ☐ Ongoing Treatment ☐ Cured

☐ If others, please specify _____

Biopsy report: ☐ Malignant ☐ Non-Malignant ☐ Not Applicable

Consultation Date: _____

Hospital Name: _____

Please share details of your treatment:

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

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

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

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

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

   Please share details for your current medication <name of the person proposed to be insured>

   (i) If exact diagnosis is Hypertension then please provide details of the below questions

   Exact Diagnosis: _____

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

   Diagnosis Date: _____ Consultation Date: _____

   (ii) If exact diagnosis is Diabetes then please provide details of the below questions

   Exact Diagnosis: _____

   Takes insulin ☐ Yes ☐ No

   Diagnosis Date: _____ Consultation Date: _____

   (iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:

   Exact Diagnosis: _____

   Diagnosis Date: _____

   Consultation Date: _____

   Medicine Name: _____

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

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

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

   Date of tests: _____

   Type of tests: _____

   Findings of tests: _____

   Please upload the investigation tests results

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

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

   Exact Diagnosis: _____ Diagnosis Date: _____

   Consultation Date: _____

   Hospital Name: _____

   Please share details of your past medical condition

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

   Please share your expected delivery date with us

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

If Yes, Kindly tick the specific boxes that are applicable:

☐ Amputation
☐ Musculoskeletal / Locomotor
☐ Neurological / Cerebral Palsy
☐ Polio
☐ Spinal cord
☐ Stroke
☐ Visual / Hearing disability
☐ Others

Kindly provide a detailed description for all boxes ticked above: _____

**LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]**

[TO BE FILLED ONLY IF my: health Critical Illness or Her Horizon or both add-on/s is /are opted]

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Cigarette(s) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Bidi(s) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Tobacco Pouches | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Gutka Pouches | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Alcohol (Quantity) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Drugs_(Quantity) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |

## MEDICAL 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 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]

1. Has an ailment or disability or deformity ☐ Yes ☐ No. If Yes, please provide the below details

Please tick additional information about your ailment for

☐ Hypertension/ High blood pressure
☐ Diabetes/ High blood sugar/Sugar in urine
☐ Cancer, Tumour, Growth or Cyst of any kind
☐ Chest Pain/ Heart Attack or any other Heart Disease/ Problem
☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
☐ Kidney ailment or Diseases of Reproductive organs

- ☐ Tuberculosis/ Asthma or any other Lung disorder
- ☐ Ulcer (Stomach/ Duodenal), or any ailment of Digestive System
- ☐ Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Nervous, Psychiatric or Mental or Sleep disorder
- ☐ Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage
- ☐ Any other disease/condition not mentioned above

(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure

Exact Diagnosis:

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

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ No (If answer is 'No', below question is mandatory)

Question: Have you stopped medication on Doctor's advice? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date _____

(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine

Exact Diagnosis: ☐ Type 1 DM/IDDM ☐ Type 2 DM ☐ GDM (Gestational Diabetes)

Are you taking insulin? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date: _____

(iii) Please share details for your ailment (except for Diabetes and Hypertension)

Exact Diagnosis: _____

Diagnosis Date: _____

Treatment type: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

Current status: ☐ Pending Treatment ☐ Ongoing Treatment ☐ Cured

☐ If others, please specify _____

Biopsy report: ☐ Malignant ☐ Non-Malignant ☐ Not Applicable

Consultation Date: _____

Hospital Name: _____

Please share details of your treatment:

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

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

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

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

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

   Please share details for your current medication <name of the person proposed to be insured>

   (i) If exact diagnosis is Hypertension then please provide details of the below questions

   Exact Diagnosis: _____

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

   Diagnosis Date: _____ Consultation Date: _____

   (ii) If exact diagnosis is Diabetes then please provide details of the below questions

   Exact Diagnosis: _____

   Takes insulin ☐ Yes ☐ No

   Diagnosis Date: _____ Consultation Date: _____

   (iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:

   Exact Diagnosis: _____

   Diagnosis Date: _____

   Consultation Date: _____

   Medicine Name: _____

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

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

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

   Date of tests: _____

   Type of tests: _____

   Findings of tests: _____

   Please upload the investigation tests results

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

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

   Exact Diagnosis: _____ Diagnosis Date: _____

   Consultation Date: _____

   Hospital Name: _____

   Please share details of your past medical condition

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

   Please share your expected delivery date with us

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

If Yes, Kindly tick the specific boxes that are applicable:

☐ Amputation
☐ Musculoskeletal / Locomotor
☐ Neurological / Cerebral Palsy
☐ Polio
☐ Spinal cord
☐ Stroke
☐ Visual / Hearing disability
☐ Others

Kindly provide a detailed description for all boxes ticked above: _____

**LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]**

[TO BE FILLED ONLY IF my: health Critical Illness or Her Horizon or both add-on/s is /are opted]

☐ Cigarette(s) Per Day _____ Per Week _____ Per Month _____ since past _____ years
☐ Bidi(s) Per Day _____ Per Week _____ Per Month _____ since past _____ years
☐ Tobacco Pouches Per Day _____ Per Week _____ Per Month _____ since past _____ years
☐ Gutka Pouches Per Day _____ Per Week _____ Per Month _____ since past _____ years
☐ Alcohol (Quantity) Per Day _____ Per Week _____ Per Month _____ since past _____ years
☐ Drugs_(Quantity) Per Day _____ Per Week _____ Per Month _____ since past _____ years

## MEDICAL 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 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]

1. Has an ailment or disability or deformity ☐ Yes ☐ No. If Yes, please provide the below details

Please tick additional information about your ailment for

☐ Hypertension/ High blood pressure
☐ Diabetes/ High blood sugar/Sugar in urine
☐ Cancer, Tumour, Growth or Cyst of any kind
☐ Chest Pain/ Heart Attack or any other Heart Disease/ Problem
☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
☐ Kidney ailment or Diseases of Reproductive organs

- ☐ Tuberculosis/ Asthma or any other Lung disorder
- ☐ Ulcer (Stomach/ Duodenal), or any ailment of Digestive System
- ☐ Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder
- ☐ HIV Infection/AIDS or Positive test for HIV
- ☐ Nervous, Psychiatric or Mental or Sleep disorder
- ☐ Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
- ☐ Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders
- ☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
- ☐ Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage
- ☐ Any other disease/condition not mentioned above

(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure

Exact Diagnosis:

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

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ No (If answer is 'No', below question is mandatory)

Question: Have you stopped medication on Doctor's advice? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date _____

(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine

Exact Diagnosis: ☐ Type 1 DM/IDDM ☐ Type 2 DM ☐ GDM (Gestational Diabetes)

Are you taking insulin? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date: _____

(iii) Please share details for your ailment (except for Diabetes and Hypertension)

Exact Diagnosis: _____

Diagnosis Date: _____

Treatment type: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

Current status: ☐ Pending Treatment ☐ Ongoing Treatment ☐ Cured

☐ If others, please specify _____

Biopsy report: ☐ Malignant ☐ Non-Malignant ☐ Not Applicable

Consultation Date: _____

Hospital Name: _____

Please share details of your treatment:

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

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

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

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

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

   Please share details for your current medication <name of the person proposed to be insured>

   (i) If exact diagnosis is Hypertension then please provide details of the below questions

   Exact Diagnosis: _____

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

   Diagnosis Date: _____ Consultation Date: _____

   (ii) If exact diagnosis is Diabetes then please provide details of the below questions

   Exact Diagnosis: _____

   Takes insulin ☐ Yes ☐ No

   Diagnosis Date: _____ Consultation Date: _____

   (iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:

   Exact Diagnosis: _____

   Diagnosis Date: _____

   Consultation Date: _____

   Medicine Name: _____

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

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

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

   Date of tests: _____

   Type of tests: _____

   Findings of tests: _____

   Please upload the investigation tests results

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

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

   Exact Diagnosis: _____ Diagnosis Date: _____

   Consultation Date: _____

   Hospital Name: _____

   Please share details of your past medical condition

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

   Please share your expected delivery date with us

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

If Yes, Kindly tick the specific boxes that are applicable:

☐ Amputation
☐ Musculoskeletal / Locomotor
☐ Neurological / Cerebral Palsy
☐ Polio
☐ Spinal cord
☐ Stroke
☐ Visual / Hearing disability
☐ Others

Kindly provide a detailed description for all boxes ticked above: _____

**LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]**

[TO BE FILLED ONLY IF my: health Critical Illness or Her Horizon or both add-on/s is /are opted]

☐ Cigarette(s) Per Day _____ Per Week _____ Per Month _____ since past _____ years
☐ Bidi(s) Per Day _____ Per Week _____ Per Month _____ since past _____ years
☐ Tobacco Pouches Per Day _____ Per Week _____ Per Month _____ since past _____ years
☐ Gutka Pouches Per Day _____ Per Week _____ Per Month _____ since past _____ years
☐ Alcohol (Quantity) Per Day _____ Per Week _____ Per Month _____ since past _____ years
☐ Drugs_(Quantity) Per Day _____ Per Week _____ Per Month _____ since past _____ years

## MEDICAL 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 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]

1. Has an ailment or disability or deformity ☐ Yes ☐ No. If Yes, please provide the below details

Please tick additional information about your ailment for

☐ Hypertension/ High blood pressure
☐ Diabetes/ High blood sugar/Sugar in urine
☐ Cancer, Tumour, Growth or Cyst of any kind
☐ Chest Pain/ Heart Attack or any other Heart Disease/ Problem
☐ Liver or Gall Bladder ailment/Jaundice/Hepatitis B or C
☐ Kidney ailment or Diseases of Reproductive organs

☐ Tuberculosis/ Asthma or any other Lung disorder
☐ Ulcer (Stomach/ Duodenal), or any ailment of Digestive System
☐ Any Blood disorder (example Anaemia, Haemophilia, Thalassaemia) or any genetic disorder
☐ HIV Infection/AIDS or Positive test for HIV
☐ Nervous, Psychiatric or Mental or Sleep disorder
☐ Stroke/ Paralysis/ Epilepsy (Fits) or any other Nervous disorder (Brain/ Spinal Cord etc.)
☐ Abnormal Thyroid Function/ Goiter or any Endocrine organ disorders
☐ Eye or vision disorders/ Ear/ Nose or Throat diseases
☐ Arthritis, Spondylitis, Fracture or any other disorder of Muscle Bone/ Joint/ Ligament/ Cartilage
☐ Any other disease/condition not mentioned above

(i) Please share details for your ailment if exact diagnosis is Hypertension/High Blood pressure

Exact Diagnosis:

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

Are you taking Anti-Hypertensive Drugs? ☐ Yes ☐ No (If answer is 'No', below question is mandatory)

Question: Have you stopped medication on Doctor's advice? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date _____

(ii) Please share details for your ailment if exact diagnosis is Diabetes / High blood sugar / Sugar in urine

Exact Diagnosis: ☐ Type 1 DM/IDDM ☐ Type 2 DM ☐ GDM (Gestational Diabetes)

Are you taking insulin? ☐ Yes ☐ No

Diagnosis Date: _____ Hospital Name: _____

Consultation Date: _____

(iii) Please share details for your ailment (except for Diabetes and Hypertension)

Exact Diagnosis: _____

Diagnosis Date: _____

Treatment type: ☐ Medical ☐ Surgical

Complications / Recurrence: ☐ Yes ☐ No

Current status: ☐ Pending Treatment ☐ Ongoing Treatment ☐ Cured

☐ If others, please specify _____

Biopsy report: ☐ Malignant ☐ Non-Malignant ☐ Not Applicable

Consultation Date: _____

Hospital Name: _____

Please share details of your treatment:

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

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

Exact Diagnosis: _____

Diagnosis Date: _____

Consultation Date: _____

Hospital Name: _____

Proposed Surgery: _____

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

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

   Please share details for your current medication <name of the person proposed to be insured>

   (i) If exact diagnosis is Hypertension then please provide details of the below questions

   Exact Diagnosis: _____

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

   Diagnosis Date: _____ Consultation Date: _____

   (ii) If exact diagnosis is Diabetes then please provide details of the below questions

   Exact Diagnosis: _____

   Takes insulin ☐ Yes ☐ No

   Diagnosis Date: _____ Consultation Date: _____

   (iii) If exact diagnosis is other than Hypertension and Diabetes please provide details of the below questions:

   Exact Diagnosis: _____

   Diagnosis Date: _____

   Consultation Date: _____

   Medicine Name: _____

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

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

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

   Date of tests: _____

   Type of tests: _____

   Findings of tests: _____

   Please upload the investigation tests results

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

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

   Exact Diagnosis: _____ Diagnosis Date: _____

   Consultation Date: _____

   Hospital Name: _____

   Please share details of your past medical condition

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

   Please share your expected delivery date with us

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

If Yes, Kindly tick the specific boxes that are applicable:

| | |
|---|---|
| ☐ Amputation | ☐ Musculoskeletal / Locomotor |
| ☐ Neurological / Cerebral Palsy | ☐ Polio |
| ☐ Spinal cord | ☐ Stroke |
| ☐ Visual / Hearing disability | ☐ Others |

Kindly provide a detailed description for all boxes ticked above: _____

**LIFESTYLE QUESTIONS [RELEVANT SECTION TO BE FILLED]**

[TO BE FILLED ONLY IF my: health Critical Illness or Her Horizon or both add-on/s is /are opted]

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Cigarette(s) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Bidi(s) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Tobacco Pouches | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Gutka Pouches | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Alcohol (Quantity) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |
| ☐ | Drugs_(Quantity) | Per Day _____ | Per Week _____ | Per Month _____ | since past _____ years |

## PAYMENT DETAILS

| | | |
|---|---|---|
| Premium Details: Amount Rs. | | |
| Premium Payment Options – ☐ Single / ☐ Monthly / ☐ Quarterly / ☐ Half Yearly / ☐ Annual | | |
| Premium Payment Options – ☐ Cheque / ☐ DD / ☐ Card / ☐ ECS / ☐ Wallet | | |
| Instrument Details: | Date | |

## 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.)

**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. 10 Lakhs.

## 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: _____

Time: _____ Place: _____

## 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:** _____

## 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. Customer Experience Management, Customer Happiness Center: D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai - 400 078. For Claim/Policy related queries call us at 022 6158 2020 / 022 6234 6234 or Visit Help Section on www.hdfcergo.com for policy copy/tax certificate/make changes/register & track claim. Product Name: Optima Restore | Product UIN: HDFHLIP25012V082425 | Product Code: HE/RL/Health/24-25/250 | Protector Rider - HDHHLIP21335V022021 | Individual Personal Accident Rider - APOPAIP19004V011920 | Hospital Daily Cash Rider - HDHHLIP21344V022021 | Critical Advantage Rider HDHHLIP21342V022021 | my:health Critical Illness - HDFHLIA22141V032122 | Optima Wellbeing (Add-on) - HDFHLIA24099V012324 | Limitless : HDFHLIA25045V012425 | ABCD Chronic Care : HDFHLIA25044V012425 |Parenthood : HDFHLIA25046V012425|