Proposal Form - my:health Critical Suraksha Plus

Cancer Suraksha Plan

Photograph

Application No

1. Please fill the form in BLOCK LETTERS. All details with* are mandatory.
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". Please leave one box blank between two words while writing address.
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				
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 in Permanent address below:				
Permanent Address				
E-Mail				
GSTIN / UIN (if any)				
Marital Status				
Contact Number				
Permanent Account Number (PAN)				
I have eIA	☐ Yes		☐ No	
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	☐ 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 investable assets for more than INR 5 crores? *(Investable assets like cash holdings, deposits, stocks and bonds etc.)*	☐ 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	

(*Either of these is mandatory)

Details of the Persons Proposed to be insured

S. No.	Name	Date of Birth	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

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, give the details of Appointee

Name of the Appointee	Relationship	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 Period: 1 Year/2Years/3YearsPolicy Period: From_____To_____

Section D: Optional Covers

Pre Diagnosis Cover	☐	
Post Diagnosis Support	☐	
Loss of Job Benefit	☐	**Sum Insured (max Up to 50% of Gross Monthly Income)** | **No of Months (Max up to 6 months)**

Add on Cover-- my: health Hospital Cash Benefit Add on

Y☐ N☐	Sum Insured options Available (Per day)	500	1,000	1,500	2,000	2,500
		3,000	5,000	7,500	10,000	

my:health Hospital Cash - Global Y☐ N☐

Existing/Previous Insurance Policy Details

Does any person proposed to be Insured presently hold any Health Insurance/Critical Illness Insurance Policies from any other Insurer? Y☐ N☐
If Yes please provide below details

Policy No. / Application No.	Insurer Name	Period of Insurance	Sum Insured	Claims lodged during the preceding years
		DD/MM/YYYY To DD/MM/YY		

* 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.

Does any person proposed to be insured presently hold any Health Insurance/Critical Illness Insurance Policies from HDFC ERGO? Y☐ N☐
If Yes please provide below details

Policy No. / Application No.	Insured Name	Period of Insurance					Sum Insured	Claims lodged during the preceding years
		DD/MM/YYYY To DD/MM/YY						

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 Critical Illness policy from HDFC ERGO.

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

Medical and life style information

Section A: Medical History: Please answer the below mentioned questions in MM - YY of diagnosed date.
Has any of the persons proposed to be insured ever suffered from / are currently suffering from any of the following:
If Yes, Please fill the relevant details as mentioned below:

Health Conditions	Insured 1	Insured 2	Insured 3	Insured 4
I. High or low blood pressure, Chest Pain, or any other cardiac disorder?	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY
II. Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY
III. Ulcer (Stomach/Duodenal),liver or gall bladder disorder or any other digestive tract disorder?	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY
IV. Kidney Failure, Stone in kidney or urinary tract, Prostate disorder or any other kidney/urinary tract disorder	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY
V. Stroke, Epilepsy (fits), Paralysis or any other nervous system (Brain, Spinal cord, etc) disorder	☐ Yes	☐ Yes	☐ Yes	☐ Yes

	Since MM - YY	Since MM – YY	Since MM – YY	Since MM – YY
VI. Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder?	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY
VII. Tumor (Swelling)-benign or malignant, any external ulcer/growth/ cyst/mass anywhere in the body?	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY
VIII. Arthritis, Spondylitis or any other disorder of the muscle/bone/joint	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY
IX. Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptresin case of refractory error)?	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY
X. HIV/AIDS or sexually transmitted diseases or any immune system disorder	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY
XI. Anemia, Leukemia, Lymphoma or any other blood/ lymphatic system disorder	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY
XII. Psychiatric/ Mental illnesses or sleep disorder	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM – YY	☐ Yes Since MM - YY
XIII. Uterine Fibroid, Fibro adenoma breast or any other Gynecological (Female reproductive system)/Breast disorder?	☐ Yes Since MM - YY	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM - YY
XIV. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxification therapy?	☐ Yes Since MM - YY	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM - YY
XV. Been under any regular medication (self/ prescribed)?	☐ Yes Since MM - YY	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM - YY
XVI. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employmentcheck-up?	☐ Yes Since MM - YY	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM - YY
XVII. Undertaken any surgery or a surgery been advised and have surgery still pending?	☐ Yes Since MM - YY	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM - YY
XVIII. Suffered from any other disease/ illness/ accident/ injury other than common cold or viral fever?	☐ Yes Since MM - YY	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM - YY
XIX. Is any of the insured pregnant? If yes please mention the expected date of delivery	☐ Yes Since MM - YY	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM - YY

XX. Any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy?	☐ Yes Since MM - YY	☐ Yes Since MM - YY	☐ Yes Since MM – YY	☐ Yes Since MM - YY

Section B: Additional medical History as per Section A& B above

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

Name: _____
(First Name) **(Middle Name)** **(Last Name)**

Mobile No: _____ **Reg No of the family doctor:** _____

Section D: Does any person proposed to be insured smoke or consume tobacco, consume gutkha / pan masala or alcohol. If yes please indicate the type and quantity per week	

Section E: In respect of any of the persons proposed to be insured (Please tick (□) the check box):	**Insured 1 Yes / No**	**Insured 2 Yes / No**	**Insured 3 Yes / No**	**Insured 4 Yes / No**
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?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
If the answer is Yes, please provide the details				

Payment & Bank Account Details

Premium Details: Amount Rs.
Premium Payment Options - Monthly / Quarterly / Half Yearly / Annual
Premium Payment Options - / Cheque / DD / Card
Cheque No:_____ **date**_____ **Bank Name**_____ **Amount: Rs**_____
Credit Card/ Debit Card No_____ **Card Type: Master**_____**Visa**_____ **Expiry Date**_____
Relationship with Proposer_____

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.

Date

Signature of the Proposer

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.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**

Agent's Declaration

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

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

Place:_____ **Date:**_____**Signature of Agent:**_____

Check List

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:**_____

Acknowledgement Customer Copy

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

Dated_____ **Drawn on**_____**Bank for a sum of ₹**_____

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

DateSignature& 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.

Cancer Suraksha Plan

	Coverage	**Details**	
Section A	**Base Covers**		
I	**Critical Illness Cover**		
1	Cancer Cover	Cancer of Specified Severity of all the organs/sites	Covered
2	Heart Cover	Illnesses and Procedures related to heart	X
3	Nervous System Cover	Illnesses and Procedures related to nervous system	X
4	Other Major Organ Cover	Illnesses and Procedures related to Major Organs and Functions	X
Section B	my:health Active	Wellness Benefits as below: 1. Fitness discount @ Renewal 2. Health Incentive 3. Wellness services	Covered
Section C	preventive Health Check Up	Free health check-up for listed tests every year	Covered
Section D	**Optional Covers**		
1	Pre Diagnosis Cover	Benefit for listed diagnostic tests for any of the covered Illness, upto Rs 25,000	Optional
2	Post Diagnosis Support		Optional

	a. Second Medical Opinion	Second expert medical opinion, E opinion as well as in person, upto Rs 10,000	
	b. Molecular Gene Expression Profiling Test	Molecular Gene Expression Profiling Test - once in Policy term, upto Rs 10,000	
	c. Post Diagnosis Assistance	Post diagnosis counselling expenses, Upto Rs 3,000 per session for up to maximum of 6 sessions	
3	Loss of Job	Benefit upon resignation or termination due to diagnosis of any of the covered illness upto 50% of Monthly Salary, upto 6 months	Optional
	Add On cover		
1	my: health Hospital Cash Benefit Add on	Hospital benefit as opted in case of hospitalisation, (max for 30 days)	Optional