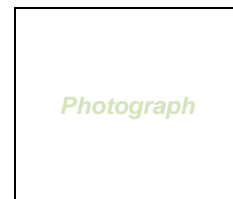




Proposal Form - my:health Critical Suraksha Plus

Smart Suraksha Plan



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	<input type="checkbox"/> Resident Indian	<input type="checkbox"/> NRI / OCI	
Current Country of Residence			
Address			
<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
I would like to apply for eIA	<input type="checkbox"/> Karvy	<input type="checkbox"/> CAMS	<input type="checkbox"/> NSDL <input type="checkbox"/> CDSL
Annual Income	<input type="checkbox"/> Upto 2.5 Lac	<input type="checkbox"/> 2.5 Lac to 5 Lac	
	<input type="checkbox"/> 5 Lac to 15 Lac	<input type="checkbox"/> 15 Lac to 30 Lac	
	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>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</i>			
Occupation	<input type="checkbox"/> Salaried	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Business Owner
	<input type="checkbox"/> Student	<input type="checkbox"/> Housewife	<input type="checkbox"/> Retired
	<input type="checkbox"/> Others		
	If others, please select source of income whichever is applicable:		
	<input type="checkbox"/> Rentals		
	<input type="checkbox"/> Interest		
	<input type="checkbox"/> Pension		



Industry Type	<input type="checkbox"/> Investment	<input type="checkbox"/> Art dealer	<input type="checkbox"/> Jewellery
	<input type="checkbox"/> Antique dealer	<input type="checkbox"/> Mining	<input type="checkbox"/> Shipping
	<input type="checkbox"/> Import-Export	<input type="checkbox"/> Agriculture	<input type="checkbox"/> Stock Broking
	<input type="checkbox"/> Scrap Dealing	<input type="checkbox"/> Real Estate	<input type="checkbox"/> Manufacturing
	<input type="checkbox"/> if Others, please specify _____		
Is your total aggregate premium across all products with HDFC ERGO General Insurance Company Limited more than INR 2 lakhs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have investable assets for more than INR 5 crores? ( <i>Investable assets like cash holdings, deposits, stocks and bonds etc.</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is your total aggregate premium across all retail products with HDFC ERGO General Insurance Company Limited INR 30 lakhs or more?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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/3Years Policy Period: From \_\_\_\_\_ To \_\_\_\_\_

**Optional Covers**

Pre Diagnosis Cover	<input type="checkbox"/>	
Post Diagnosis Support	<input type="checkbox"/>	
Loss of Job Benefit	<input type="checkbox"/>	Sum Insured ( max Up to 50% of Gross Monthly Income)
		No of Months (Max up to 6 months)

**Add On Covermy: health Hospital Cash Benefit Add on**

Y <input type="checkbox"/> N <input type="checkbox"/>	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?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
II. Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
III. Ulcer (Stomach/Duodenal),liver or gall bladder disorder or any other digestive tract disorder?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
IV. Kidney Failure, Stone in kidney or urinary tract, Prostate disorder or any other kidney/urinary tract disorder	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
V. Stroke, Epilepsy (fits), Paralysis or any other nervous system (Brain, Spinal cord, etc) disorder	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
VI. Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
VII. Tumor (Swelling)-benign or malignant, any external ulcer/growth/ cyst/mass anywhere in the body?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
VIII. Arthritis, Spondylitis or any other disorder of the muscle/bone/joint	<input type="checkbox"/> Yes Since	<input type="checkbox"/> Yes Since	<input type="checkbox"/> Yes Since	<input type="checkbox"/> Yes Since

	MM - YY	MM - YY	MM - YY	MM - YY
IX. Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptresin case of refractory error)?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
X. HIV/AIDS or sexually transmitted diseases or any immune system disorder	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
XI. Anemia, Leukemia, Lymphoma or any other blood/ lymphatic system disorder	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
XII. Psychiatric/ Mental illnesses or sleep disorder	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
XIII. Uterine Fibroid, Fibro adenoma breast or any other Gynecological (Female reproductive system)/Breast disorder?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
XIV. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxification therapy?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
XV. Been under any regular medication (self/ prescribed)?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
XVII. Undertaken any surgery or a surgery been advised and have surgery still pending?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
XVIII. Suffered from any other disease/ illness/ accident/ injury other than common cold or viral fever?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
XIX. Is any of the insured pregnant? If yes please mention the expected date of delivery	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY
XX. Any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy?	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> Yes Since MM - YY	<input type="checkbox"/> 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: \_\_\_\_\_

<b>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</b>	
--	--

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?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
If the answer is Yes, please provide the details				

**Payment & Bank Account Details**

<b>Premium Details: Amount Rs.</b>
<b>Premium Payment Options - Monthly / Quarterly / Half Yearly / Annual</b>
<b>Premium Payment Options - / Cheque / DD / Card</b>
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.)

<b>Name of the Translator / Representative</b>		<b>Signature of the Translator / Representative</b>
<b>Place</b>		
<b>Date</b>		

<b>Name of the Proposer</b>		<b>Signature of the Proposer</b>
<b>Place</b>		
<b>Date</b>		

**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.

**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 30 days.

**Smart Suraksha Plan**

	Coverage	Details	
<b>Section A</b>	<b>Base Covers</b>		
<b>I</b>	<b>Critical Illness Cover</b>		
1	Cancer Cover	Cancer of Specified Severity of all the organs/sites	X
2	Heart Cover	Illnesses and Procedures related to heart	Covered
3	Nervous System Cover	Illnesses and Procedures related to nervous system	Covered
4	Other Major Organ Cover	Illnesses and Procedures related to Major Organs and Functions	X
<b>Section B</b>	my:health Active	Wellness Benefits as below: 1. Fitness discount @ Renewal 2. Health Incentive 3. Wellness services	Covered
<b>Section C</b>	preventive Health Check Up	Free health check-up for listed tests every year	Covered
<b>Section D</b>	<b>Optional Covers</b>		
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, up to Rs 10,000	
	b. Molecular Gene Expression Profiling Test	Molecular Gene Expression Profiling Test - once in Policy term, up to Rs 10,000	



	c. Post Diagnosis Assistance	Post diagnosis counselling expenses, Upton 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 up to 50% of Monthly Salary, up to 6 months	Optional
	<b>Add On cover</b>		
1	my: health Hospital Cash Benefit Add on	Hospital benefit as opted in case of hospitalisation, (max for 30 days)	Optional