HDFC ERGO General Insurance Company Limited

HDFC ERGO GENERAL INSURANCE

Health Suraksha - Proposal Form

(All fields are mandatory and fill in CAPITALS only)

Application Number _____ Branch Manger Code _____ TSE Code _____

Sourcing Channel / Agent / Broker Name

CP Code Sourcing Branch (City)

PROPOSER DETAILS

Proposer Mr. / Ms. / Mrs.

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

Address

City Pin Code Sex Male Female

State Proposer Date of Birth D D M M Y Y Y Y

Tel.(Res.) (Off.) Mobile

STD Code STD Code

Email

ID Proof Type PAN Passport Driving License Voters Card Others

PLAN DETAILS

Plan Name Silver Type of Cover Individual Family Floater Proposed Policy Period D D M M Y Y Y Y to D D M M Y Y Y Y

DETAILS OF THE PERSON PROPOSED TO BE INSURED

S.No.	Name of the Insured person	Relationship	Gender*	Date of Birth	Sum Insured
1.				D D M M Y Y Y Y	
2.				D D M M Y Y Y Y	
3.				D D M M Y Y Y Y	
4.				D D M M Y Y Y Y	

*Gender Code M (Male), F (Female)

PHOTOGRAPHS [If available]

Please paste the photographs in sequence (Insured 1, Insured 2, Insured 3 and Insured 4) as specified in section 3 of details of proposed to be insured.

Insured 1	Insured 2	Insured 3	Insured 4

NOMINEE DETAILS

Name_____ Relationship_____

EXISTING/PREVIOUS INSURANCE DETAILS

(Including any with HDFC ERGO General Insurance Company Ltd.)

Insurer Name	Sum Insured (Rs.)	Policy Name	Policy No / Application No	Period of Insurance [From / To]	Claims lodged during the preceding 3 years

PREMIUM DETAILS

Amount Rs. Rupees _____

SOURCES OF FUND

Salary Business Other (Please Specify) _____

BANK ACCOUNT DETAILS*

Bank Account No. Bank Name _____

Branch Name & Address _____ Annual Gross Income ₹

MEDICAL AND LIFE STYLE INFORMATION

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

Section A: Have any of the Insured ever suffered from/currently suffering from any of the following	**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**
1. Hypertension, Chest Pain, Ischemic heart disease or any other cardiac disorder				
2. Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder				
3. Ulcer(Stomach/Duodenal),Hepatitis, Cirrhosis or any other digestive or liver/ gallbladder disorder				
4. Renal Failure, Calculus or any other kidney/urinary tract or prostate disorder				
5. Dizziness, Stroke, Epilepsy, Paralysis or other brain/ nervous system disorder				
6. Diabetes, Thyroid Disorder or any other endocrine disorder				
7. Tumor-benign or malignant, any ulcer/growth/cyst				
8. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint				
9. Diseases of the Nose/Ear/Throat/Dental/ Eye(please mention diopters)				
10. HIV/AIDS or sexually transmitted diseases or any immune system disorder				
11. Anaemia, Leukemia or any other blood/lymphatic system disorder				
12. Psychiatric/Mental illnesses or sleep disorder				
13. DUB, Fibroid, Cyst/Fibroadenoma or any other Gynecological/Breast disorder (for female lives only				
Section B: Have any of the Insured persons:	**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**
14. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxicating therapy				
15. Been under any Regular medication (self/ prescribed)				
16. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years				
17. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending				
18. Suffered from any other disease/illness/accident/injury				
19. Is any of the insured pregnant? If yes please mention the expected date of delivery				
20. Any complaint of Diabetes, Hypertension or any complication during current or earlier pregnancy				

ACKNOWLEDGMENT - CUSTOMER COPY

Please retain this counterfoil for your records

Section C: Name of Illness/Medicine/Test/Surgery/ diopter grade (for questions answered as Yes in Section A & B)	Diagnosis date	Date of Last Consultation	Treatment in / out patient	Doctor/Hospital Name and Phone No.
Insured 1				
Insured 2				
Insured 3				
Insured 4				

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

Family Doctor Mr. / Ms. / Mrs. (First Name) (Middle Name) (Last Name)

Address

City Pin Code Qualifcation

State Sex Male Female

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

Email

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

PAYMENT DETAILS

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

Cheque Please pay by crossed cheque (account payee only) in the name of HDFC ERGO General Insurance Company Ltd.

Cheque No. Bank Name

Branch City

Dated D D M M Y Y Y Y For (Rs.)

Credit Card No.

Credit Card Master Visa Expiry Date D D M M Y Y Y Y Relationship to the Insured

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

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

War or any act of war, invasion, act of foreign enemy, war like operations, nuclear weapons/materials radiation of any kind, committing or attempting to commit a criminal or illegal act, participation or involvement in naval, military or air force operation or any hazardous or dangerous or adventurous activities, including but not limited to racing, diving, aviation, scuba diving, , parachuting, hang-gliding, rock or mountain climbing, abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as drugs and alcohol, smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services,, intentional self injury or attempted suicide, obesity/morbid obesity and any weight control program, Psychiatric, mental or nervous disorders, Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), external congenital diseases, genetic disorders, stem cell implantation or surgery or growth hormone therapy, "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus), venereal disease, sexually transmitted disease, sterility / infertility treatment of any type, birth control, contraceptive supplies or services, pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy treatment of spinal subluxation, diagnosis and, treatment by manipulation of the skeletal structure or for muscle stimulation by any means (except treatment of fractures and dislocations of the extremities), dental treatment not requiring Hospitalization, Nasal septum deviation and nasal concha resection, circumcisions, laser treatment for refractive error, aesthetic or change-of-life treatments, plastic Surgery or Cosmetic other than for reconstruction following an Accident or Illness otherwise covered under this Policy, experimental, investigational or unproven treatment devices and pharmacological regimens, measures primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the diagnosis and treatment, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care, all preventive care, vaccination including inoculation and immunizations, any non allopathic treatment, enteral feedings and other nutritional and electrolyte supplements, unless required as a direct consequence of an otherwise covered claim, charges related to a Hospital stay not expressively mentioned as being covered, Personal comfort and convenience items, vitamins and tonics, treatments rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed, out-station consultations and referral-fees, treatment by Medical and non-Medical Practitioners and clinics from where the bills have been excluded for payments by the insurer for certain reasons, treatments rendered by a Medical Practitioner who shares the same residence as an Insured Person or who is a member of an Insured Person's Family, the provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, diabetic test strips, and similar products. Or artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment, any treatment that is not of a reasonable cost, not medically necessary; non-prescription drugs, crutches or any other external appliance and/or device used for diagnosis or treatment.

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

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

COINSURANCE OPTION

I agree to exercise Coinsurance option with HDFC ERGO General Insurance Company Ltd. (Lead insurer) and Apollo MUNICH Insurance Company Ltd. (Co-Insurer). Notwithstanding the role and liability of the Co-insurer in terms of the above co-insurance arrangement, for the avoidance of doubt, it is hereby declared that under the above co-insurance arrangement the Lead Insurer is the Insurer for all Policy purposes including but not limited to the collection of premium, policy administration, notices, policy and claims decisions, and the payment of claims

INSURER'S DECLARATION

Note: 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 Ltd. along with the premium payment does not tantamount to the acceptance of the Proposal for insurance by HDFC ERGO General Insurance Company Ltd. 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 Ltd, such acceptance shall be specifically intimated to the Proposer by HDFC ERGO General Insurance Company Ltd. along with the date from which the insurance Cover shall become effective. HDFC ERGO General Insurance Company Ltd shall not be liable for any claim in respect of an event giving rise to a claim covered under the Policy of Insurance that has occurred prior to policy issuance is not covered under this policy (Your proposal form will be considered after HDFC ERGO General Insurance Company Ltd. receives premium payment.) You are obliged to inform HDFC ERGO General Insurance Company Ltd. without any delay & in writing of all doctors or other members of medical profession whom you or any of the proposed member have consulted & all changes in your or any other proposed members' state of health between the fling of this application form & inception of your insurance cover. If you are in any doubt, please seek the advice of your insurance advisor.

Fraud Warning: This policy shall be voidable at the option of the Company in the event of mis-representation, mis-description or non-disclosure of any material particulars by the Proposer. Any person who, knowingly and with intent to defraud the insurance company or any other person, files a proposal for insurance containing any false information, or conceals for the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, which will render the policy voidable at the sole discretion of the insurance company and result in a denial of insurance benefits.

Anti-Rebating Warning : As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited, as follows: No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance policy in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.

Violations of Section 41 of the Insurance Act 1938, as amended, shall be punishable with a fine which may extend to five hundred (500) Rupees.

Insurance is the subject matter of solicitation

Place

Date D D M M Y Y Y Y

Signature of the Proposer

FOR OFFICE USE ONLY

Channel Partner Code

Branch Location

Signature of Channel Partner

ACKNOWLEDGEMENT - CUSTOMER COPY

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

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

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

Date D D M M Y Y Y Y

Signature & seal _____

Your proposal is subject to acceptance by the Company. This acknowledgment should not be construed as assumption of risk by the Company. 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.