



## Health Suraksha - Proposal Form

(All fields are mandatory and fill in CAPITALS only)

Application Number \_\_\_\_\_

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 \_\_\_\_\_  
 State \_\_\_\_\_ Sex Male  Female   
 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 DDMMYY to DDMMYY

### 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 |
|-----------|-----------|-----------|-----------|
|           |           |           |           |

### 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 Rs. \_\_\_\_\_

### 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)  |                  |                  |                  |                  |
| <b>Section B: Have any of the Insured persons:</b>                                                      | <b>Insured 1</b> | <b>Insured 2</b> | <b>Insured 3</b> | <b>Insured 4</b> |
| 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<br>(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  Qualification

State  Sex Male  Female

Tel.(Res.)  (Off.)  STD Code  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 fill 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  For (Rs.)  Credit Card No.

**Credit Card** Master  Visa  Expiry Date  Relationship to the Insured

Card Holders Name Mr. / Ms. / Mrs.

(If different from insured) (First Name) (Middle Name) (Last Name)

**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 expressly 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 hereby declare and warrant on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects and that there is no other information which is relevant to this application for insurance that has not been disclosed to HDFC ERGO General Insurance Company Ltd. I agree that this proposal and the declarations shall be the basis of the contract between me and all persons to be insured and HDFC ERGO General Insurance Company Ltd. I further consent and authorize HDFC ERGO General Insurance Company Ltd. and/or any of their authorized representatives to seek medical information from any hospital/consultant that I or any person proposed to be insured has attended or may attend in future concerning any disease or illness or injury.

I understand that all information provided in this proposal form and any attachments are material to the insurer's decision to provide this insurance, and that insurance will be provided, at the insurer's sole discretion, in reliance upon the truth of such information.

**COINSURANCE OPTION**

I agree to exercise Coinsurance option with HDFC ERGO General Insurance Company Ltd. (Lead insurer) and Apollo DKV 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 filing of this application form & inception of your insurance cover. If you are in any doubt, please seek the advice of your insurance advisor.

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

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

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

Place

Date

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  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.