

# HDFC ERGO General Insurance Company Limited

# HDFC ERGO

GENERAL INSURANCE

## HEALTH SURAKSHA - TOP UP PLUS - PROPOSAL FORM

Please fill-up this form in CAPITAL LETTERS

### SOURCING CHANNEL/AGENT/BROKER

Name

CP Code  Sourcing Branch (city)

### PROPOSER DETAILS

Proposer Name (Mr/Mrs/Ms)

First Name  Middle Name  Last Name

Address

District

City/Town  State  Pin Code

Gender Male  Female  Telephone  Mobile

E-Mail

ID Proof Type: PAN  Passport  Driving License  Voter's Card  Others

ID Proof No:

### PLAN DETAILS

Type of Cover Individual  Family Floater

Sum Insured (Rs.): 200,000  300,000  400,000  500,000  750,000  1000,000

Deductible (Rs.): 100,000  200,000  300,000  400,000  500,000

Proposed Policy Period: From  To

### DETAILS OF THE PERSON PROPOSED TO BE INSURED

S.No	Name of The Insured Person	Height (cms)	Weight (kg)	Relationship to Policyholder	Gender (M/F)	Date of Birth (DD/MM/YYYY)	Occupation
1							
2							
3							
4							

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

### PHOTOGRAPHS (if available)

Please paste the photographs in sequence [Insured Person 1, Insured Person 2, Insured Person 3, Insured Person 4] as specified in section 3 of details of persons proposed to be insured

Insured 1	Insured 2	Insured 3	Insured 4

### NOMINEE DETAILS

In the event of the death of an Insured Person any payment due under the Policy shall become payable to the nominee in accordance with the Policy terms and conditions. The nominee must be an immediate relative of the Proposer. For all other persons proposed to be insured, the Proposer shall be the Nominee.

Nominee Name	Relationship	Address of the Nominee

### EXISTING/PREVIOUS INSURANCE DETAILS

Is the proposer or any of the persons proposed, already Insured under a plan with HDFC ERGO General Insurance Company Limited or any other insurer or is a proposal pending for Policy issuance? If yes, please indicate below the Policy/ Application number(s) (Please mention application number in case of pending proposal.) Since when are continuously insured:

Do you want Us to consider these details for continuity? Yes  No

Insurer Name	Sum Insured	Policy Name	Policy No/Application No	Period of Insurance		Claim Lodged during the preceding 3 years
				From	To	
				DD/MM/YYYY	DD/MM/YYYY	
				DD/MM/YYYY	DD/MM/YYYY	
				DD/MM/YYYY	DD/MM/YYYY	
				DD/MM/YYYY	DD/MM/YYYY	

### MEDICAL AND LIFESTYLE INFORMATION

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

Section A: Have any of the persons proposed to be insured ever suffered from/currently suffering from any of the following :	Insured 1	Insured 2	Insured 3	Insured 4
i. Hypertension, chest pain, Ischemic heart disease or any other cardiac disorder				
ii. Tuberculosis, asthma, bronchitis or any other lung/ respiratory disorder				
iii. Ulcer (stomach/duodenal), hepatitis, cirrhosis or any other digestive or liver/ gallbladder disorder				
iv. Renal failure, calculus or any other kidney/urinary tract or prostate disorder				
v. Dizziness, stroke, epilepsy, paralysis or other brain/nervous system disorder				
vi. Diabetes, thyroid disorder or any other endocrine disorder				
vii. Tumor-benign or malignant, any ulcer/growth/ cyst				
viii. Arthritis, spondylosis or any other disorder of the muscle/bone/joint				
ix. Diseases of the nose/ear/throat/teeth/ eye (please mention dioptries)				
x. HIV/AIDS or sexually transmitted diseases or any immune system disorder				
xi. Anaemia, leukaemia or any other blood/lymphatic system disorder				
xii. Psychiatric/mental illnesses or sleep disorder				
xiii. DUB, fibroid, cyst/fibroadenoma or any other gynecological/breast disorder				

### ACKNOWLEDGMENT - CUSTOMER COPY

Please retain this counterfoil for your records

Section B: Have any of the persons proposed to be insured:	Insured 1	Insured 2	Insured 3	Insured 4
xiv. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication therapy				
xv. Been under any regular medication (self/ prescribed)				
xvi. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years				
xvii. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending				
xviii. Suffered from any other disease/illness/ accident/injury				
xix. Is any of the insured persons pregnant? If yes please mention the expected date of delivery				
xx. Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy				

Section C: Name and details of Illness/ Medicine/Test/ Surgery/Diopter grade (for questions answered as Yes in Section A & B)	Diagnosis Date	Date of Last Consultation	Treatment in/outpatient	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

Name: \_\_\_\_\_ Qualification: \_\_\_\_\_

Address: \_\_\_\_\_

Pin Code: \_\_\_\_\_ Phone No. \_\_\_\_\_ Mobile No. \_\_\_\_\_ Email ID. \_\_\_\_\_

Section E: Does any 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				

### BANK PAYMENT DETAILS

Name of the Bank Account Holder \_\_\_\_\_

Cheque No. \_\_\_\_\_ Name of Bank \_\_\_\_\_ Dated

Bank Account No. \_\_\_\_\_ Branch \_\_\_\_\_ Account: Savings  Current  For Rs. \_\_\_\_\_

MICR Code  digit MICR code number of the bank and \_\_\_\_\_ IFSC Code (11 character code appearing on your cheque leaf) \_\_\_\_\_

branch appearing on the cheque issued by the bank)

I wish:  Any refund due on the premium payment / any payment/claims will be directly credited to my aforesaid Bank Account.\*  
 \*As per the IRDA, its mandatory that all payments made to the insured only through electronic mode.

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 Limited'.

Credit Card: Master  Visa  Expiry Date  Credit Card No. \_\_\_\_\_

Card Holders Name Mr/Ms/Mrs. \_\_\_\_\_

Relationship to the Insured \_\_\_\_\_

Additional Information: (If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

### GENERAL EXCLUSIONS

The following is an outline of the general exclusions under the policy. For more details on the exclusions and the waiting periods please refer to the policy wordings before purchasing this policy.

30 days waiting period in the first year and is not applicable in subsequent renewals: 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 breach of law with criminal intent, or intentional self injury or attempted suicide while sane or insane; participation or involvement in naval, military or air force operation or any hazardous or dangerous or adventurous activities including but not limited to racing, driving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing; abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services or supplies; treatment of obesity or any weight control program; psychiatric, mental disorders, Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), congenital internal or external diseases, genetic disorders, stem cell implantation or surgery or growth hormone therapy; sleep apnoea; venereal disease, sexually transmitted disease, "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus) sterility / infertility treatment of any type; pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy; treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, muscle stimulation by any means except for treatment of fractures other than hairline fractures and dislocations of the mandible and extremities; dental treatment unless requiring hospitalization; treatment of nasal concha resection, circumcisions unless necessitated by illness or injury and forming part of treatment, laser treatment for correction of eye due to refractive error, aesthetic or change-of-life treatments; plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment for reconstruction following an Accident, Cancer or Burns; 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; convalescence, 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 (except in case of post-bite treatment); any non allopathic treatment; enteral feedings and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim; charges related to a Hospital stay not expressly mentioned as being covered, items of personal comfort and convenience, vitamins and tonics; treatments rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; 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; costs of any procedure or treatment by any person or institution that we have told you (in writing) is not to be used: the provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, nebulizer and similar products; any treatment or part of treatment that is not of a reasonable cost, not medically necessary; drugs or treatment which are not supported by a prescription including medicines/treatment taken beyond the prescribed limit; artificial limbs, 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.
- I agree to HDFC ERGO General Insurance Company Limited taking appropriate measures to capture the voice log for all such telephonic transactions carried out by me, in accordance with procedures/regulations.

Signature of the Proposer: \_\_\_\_\_ Place: \_\_\_\_\_ Date: DDMMYYYY

### COINSURANCE OPTION

I agree to exercise Coinsurance option with HDFC ERGO General Insurance Company Ltd. (Lead insurer) and Apollo Munich Health 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 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 limited 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 HDFC ERGO General Insurance Company Limited receives premium payment.)

You are obliged to inform HDFC ERGO General Insurance Company Ltd without any delay & in writing all changes in your or any other proposed members' state of health between the filling 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 misrepresentation, fraud, non-disclosure of material facts or non-cooperation by You or any Insured Person or anyone acting on Your behalf or on behalf of an Insured Person. 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.
- Any person making default in complying with the provision of this section shall be punishable with fine which may extend to five hundred rupees.

Place: \_\_\_\_\_ Signature of the Proposer \_\_\_\_\_

Date:

FOR OFFICE USE ONLY

Channel Partner Code: \_\_\_\_\_ Branch Location: \_\_\_\_\_

Signature of Channel Partner: \_\_\_\_\_

### ACKNOWLEDGMENT - 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.

Signature & seal

Date:

Your proposal is subject to acceptance by the Company. This acknowledgement 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 realised or non-fulfillments of Pre Policy Checkup. If we do not accept the proposal, we will inform you and refund any payment received from you without interest with 30 days.