

HDFC ERGO General Insurance Company Limited



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] Mobile _____
 Tel.(Res.) _____ (Off.) _____
 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: From [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

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.

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

Name of the Bank Account Holder _____
 Bank Account No. _____ Name of Bank _____
 Branch _____ Account: Savings Current
 MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank) _____
 IFSC Code (11 character code appearing on your cheque leaf) _____

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.

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)				

ACKNOWLEDGMENT - CUSTOMER COPY

Please retain this counterfoil for your records

