



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 Pincode

State Sex Male Female

Tel.(Res.) (Off.) Mobile

STD Code STD Code

E-mail

ID Proof Type PAN Passport Driving License Voters Card Others

PLAN DETAILS

Plan Name Silver Type of cover Individual Family Floater

Proposed Policy Period to

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

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 dioptres)				
10. HIV/AIDS or sexually transmitted diseases or any immune system disorder				
11. Anaemia, Leukaemia 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 detoxication 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				

ACKNOWLEDGEMENT - CUSTOMER COPY

Please retain this counterfoil for your records

