PROPOSAL FORM **GROUP ASSURANCE HEALTH PLAN**

Application No._____

We are under no obligation to accept any proposal for insurance. 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.

PROPOSER'S DETAILS

Name of proposer : _____
Address : _____
Business of Proposer : _____

EXISTING POLICY DETAILS

Policy Period : From: _____ To _____
Details of coverage : _____
Name of the Insurance Company: _____
Number of Persons Covered: _____
Current Insurer & Branch: _____
For how many years? : _____
Claim Ratio : _____

Year	Premium	Claim Amount

DETAILS OF COVER SOUGHT

Plan Type : Individual □ Floater □
Sum Insured Opted : _____
Dependents to be covered : Spouse □ Children □ Parents □

BASE COVER

In-patient Treatment	Covered upto Sum Insured
Pre/Post Hospitalisation	30/60 days
Day Care Treatment	All day care procedures
Domiciliary Hospitalisation	Covered upto Sum Insured
Organ Donor	Covered upto Sum Insured
Ambulance Cover	Rs. 2000 per hospitalisation
Initial Waiting Period	30 days
Specific Illnesses/Treatment Waiting Period	24 months
Pre-existing disease waiting period	48 months

OPTIONAL COVER (IF OPTED ON PAYMENT OF ADDITIONAL PREMIUM)

1	Pre/Post Hospitalisation	□ 15/30 days		□ 60/90 days		□ 90/180 days
2	Room Rent Limit					
	□ No Room Rent Limit (Default)	□ 1% of sum insured Per day limit option and 2% of sum insured Per day limit option for ICU		□ 2% of sum insured Per day limit option and 4% of sum insured Per day limit option for ICU		
3	Hospital Daily Cash					
	Per day Amount (Rs)	□ 50	□ 100	□ 150	□ 200	□ 250	□ 300
		□ 400	□ 500	□ 750	□ 1000	□ 1500	□ 2000
		□ 2500	□ 3000	□ 3500	□ 4000	□ 4500	□ 5000
	No. of days	□ 15	□ 30	□ 60	□ 90	□ 180	
4	Preventive Health Check-up					
	□ At the end of a block of continuous claim free years	□ Option 1			□ Option 2		
	□ At every renewal irrespective of claim	□ Option 1			□ Option 2		
	Option 2	Upto 1% of Sum Insured at the end of every Policy Year subject to max of Rs 7500*					
	Option 2	Rs 500 to Rs 7500* (in multiples of 500)					
		*per member basis for individual policy and per policy basis for floater policies.					
5	Co-payment (For all claims under Inpatient treatment)			□ 10%	□ 15%	□ 20%	□ 30%
6	Reduction/waiver of Pre Existing Disease Waiting Period			□ Waived	□ 12 month	□ 24 month	□ 36 month
7	Reduction/waiver of 24 months Waiting Period for listed conditions				□ Waived	□ 12 month	
8	Waiver of 30 days waiting period				□ Yes	□ No	
9	AYUSH Benefit (% of Inpatient Sum Insured)			□ 10%	□ 25%	□ 50%	□ 100%
10	Second Opinion in respect of Critical Illness			□ Yes	□ No		
11	Restore Benefit			□ Yes	□ No		
12	Double Restore Benefit			□ Yes	□ No		
13	Cumulative Bonus	□ Increase/Decrease of 10% maximum of __%				□ 50%	□ 100%
14	□ Daily Cash for Choosing Shared Accommodation			□ Yes	□ No		
	Per day Amount (Rs)	□ 500	□ 800	□ 1000	□ 1500	□ 2000	
	No. of days	□ 6	□ 10	□ 15			
15	□ Critical Illness	□ 4 CI	□ 12 CI				
16	Critical Illness (Indemnity Based)	□ 100000	□ 200000	□ 300000	□ 400000	□ 500000	□ 750000
		□ 1000000	□ 1500000				
	Number of CI	□ 4 CI	□ 12 CI				
17	Double sum insured for Critical Illness (Indemnity Based)			□ 4 CI	□ 12 CI		
18	Double sum insured for Cancer of specified severity			□ Yes	□ No		
19	Outpatient Benefit	□ 1000	□ 2000	□ 3000	□ 4000	□ 5000	
	Waiting Period	□ 1 year	□ 2 years	□ 3 years			
20	Health and Wellness Portal	□ Yes	□ No				
21	Geographical Premium	□ Yes	□ No				

MEMBER DETAILS (PLEASE ATTACH THE DETAILS IN THE FOLLOWING FORMAT)

Member Name	Location	Name of Insured	Gender	Date of Birth/ Age	Relationship	Sum Insured	Nominee Name	Relationship to Nominee

PAYMENT DETAILS:

Mode of payment: ☐ Cash ☐ Cheque ☐ Electronic Clearing System (ECS)* ☐ Others _____

Cheque Number	Name of the Premium Payer	Relationship of Payer with Proposer	Bank details	Date	Amount	Pan No.

- Please make a A/c Payee Cheque/DD/Pay Order in favor of 'HDFC ERGO Health Insurance Ltd.' only.

* If ECS is selected please submit the standing instruction form available at the branch.

EXCLUSIONS:

This is only a brief summary of the exclusions in your policy, for full list of general exclusions please refer to policy terms and conditions –

All treatments within the first 30 days of cover except any accidental injury, 2 years waiting period for specified illness/ conditions, Pre-existing waiting period for 48 months for any disease, illness or condition that existed prior to taking this policy. Treatment of obesity or any weight control program, psychiatric, mental disorders, Parkinson and Alzheimer's disease, congenital external diseases, sexually transmitted disease, "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus), sterility / infertility treatment of any type, 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.

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

- ☐ I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorized to propose on behalf of these other persons.
- ☐ I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable.
- ☐ I further declare that I 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 declare that I consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/proposer and seeking information from any insurer to whom an application for insurance on the person to be insured /proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- ☐ I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.

Signature of Proposer: _____ Date: _____

Time: _____ Place: _____

SPECIFIED PERSON/AGENT'S DECLARATION:

I, _____(Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy.

I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favor pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

Specified Person / Agent Signature: _____ Date: _____

Specified Person / Agent Code: _____ Place: _____

VERNACULAR DECLARATION:

Certification in case the proposer has signed in vernacular (to be witnessed by someone other than agent/employee of the company):

Name of Proposer:

The content of this form and its particulars have been explained by me in vernacular to the proposer who has understood and confirmed the same.

Signature of Proposer: _____ Date: _____

Name of the witness: _____ Signature of the witness: _____ Place: _____

SECTION 41 OF INSURANCE ACT1938 (PROHIBITION OF REBATES):

1. 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 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 prospectuses or tables of the insurers.
2. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.

HDFC ERGO Health Insurance Limited (Formerly known as Apollo Munich Health Insurance Company Limited.) • Central Processing Centre: 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurugram-122016, Haryana • Corp. Off. 1st Floor, SCF-19, Sector-14, Gurugram-122001, Haryana • Registered Off. 101, First Floor, Inizio, Cardinal Gracious Road, Chakala, Opposite P & G Plaza, Andheri (East), Mumbai, Maharashtra 400069 India • Tel: +91-124-4584333 • Fax: +91-124-4584111 • Website: www.hdfcergohealth.com • Email: customerservice@hdfcergohealth.com • For more details on risk factors, terms and conditions please read sales brochure carefully before concluding a sale. • Tax laws are subject to change. • IRDAI Registration Number – 131 • CIN: U66030MH2006PLC331263 • UIN: APOHLGP19084V011819 • URN: AM/HLT/0002/A/012017

CHECKLIST:

Please check the following documents are attached along with the proposal form

1. ID Proof: Passport/ PAN Card/ Aadhaar Card/Voter ID/ Driving License/ Letter from a recognized public authority
2. Proof of residence: Telephone Bill/ Bank Account Statement/ Letter from any recognized public authority/Electricity Bill/ Ration Card
3. Age Proof: Birth certificate / School Leaving Certificate/ PAN Card/ Driving License/ Passport
4. Renewal Notice with claim details
5. Certification of previous insurer for previous claim details
6. Photocopies of all previous policies and endorsements

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PERFORATED ACKNOWLEDGEMENT:

Application Number _____

Name of Proposer _____

We acknowledge with thanks the receipt of your application and amount by cash/ cheque/ demand draft/ others _____ of amount Rs. _____.

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. 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 within next 15 days.

Signature and Seal: _____ Date: _____