PSRF608425071621
Comp/July/Int/4696

Policy Servicing Request Form- Health Plans - 2

For Official Use Only
Branch:
Receipt Date & Time:
Received by:
Interaction ID:

HDFC Life
Sar utha ke jiyo!

Policy Number: _____

Name of the Policyholder: _____ (First Name) _____ (Middle Name) _____ (Last Name)

☐ **ADDITION OF MEMBER** (Please fill the SMQ on page 2)

General Rules:

1. Addition of another member is applicable only to "Family Floater" plans. 2. All new members can be added only at specific events like birth, adoption and marriage. 3. All time bound exclusions and waiting period shall apply to such added members. 4. Addition of member is subject to underwriting. 5. Identity, address and age proofs of the new member(s) are to be submitted. 6. Incremental premium, if any, needs to be paid as specified at the branch. 7. Proof of marriage and adoption are to be submitted, where applicable.

I would like to add a new member (details mentioned below) to be insured as part of the above Policy.

Name: _____

Date Of Birth: _____ DD/MM/YYYY Sex: _____ Height: _____ (cms) Weight: _____ (kgs)

Reason for Addition of member: _____

Date of Marriage: _____ DD/MM/YYYY Date of Adoption: _____ DD/MM/YYYY

Relationship with Proposer: _____ Nationality: _____ Country of Residence: _____

Educational Qualification: ☐ Non-Matric ☐ Matric ☐ Graduate ☐ Postgraduate ☐ Others _____

Occupation: ☐ Salaried ☐ Self-Employed ☐ Student ☐ Housewife ☐ Others (Please specify) _____

If Salaried, specify Company Name: _____ Designation: _____ Contact No.: _____

If Self- Employed, specify business/occupation: _____

☐ **DELETION OF MEMBER**

General Rules:

1. Deletion of a member is permitted only at specific events like death and divorce of a Life Insured. 2. The attested copy of the death certificate or divorce agreement, as applicable, has to be submitted for deletion of a member. 3. The revised Premium, if any, will be applicable from the next Premium due date,

I would like to delete the below Life Insured member from the Policy mentioned above.

Name: _____ Date Of Birth: _____ DD/MM/YYYY Sex: _____

Reason for deletion: _____ Date of Divorce: _____ DD/MM/YYYY Date of Death: _____ DD/MM/YYYY

☐ **CHANGE OF LIFE INSURED/POLICYHOLDER DATE OF BIRTH**

☐ Life Insured ☐ Policyholder

General Rules

1. Incremental Premium, if any, needs to be paid as specified at the branch. 2. A valid age proof, containing the correct Date of Birth, should be submitted. 3. Change in Date of Birth is subject to underwriting.

Old Date of Birth: ____/____/_____ Revised Date of Birth: ____/____/_____

In case of change in Date of Birth of Life Insured

Name of Life Insured: _____

☐ **CUSTOMER ACKNOWLEDGEMENT COPY (POLICY SERVICING FORM FOR HEALTH PLANS 2)**

Policy No: _____ Interaction ID: _____ Name of the Policyholder: _____

PS Request: _____ Documents accepted: ☐ Original Policy Document ☐ Others

Customer Relations Officer: Date: DD/MM/YYYY Time:

Branch Stamp

For queries or more information, call us on **022-68446530** (Call charges apply) . Available Mon-Sat from 10 am to 7 pm. DO NOT prefix any country code e.g. +91 or 00. |
Email – **service@hdfclife.com | nriservice@hdfclife.com** (For NRI customers only) Visit – **www.hdfclife.com**

Note: SMQ to be filled only for Addition of Member, Conversion and Revival options.

☐ SHORT MEDICAL QUESTIONNAIRE (SMQ) for Health: Details of the Life to be Insured

SECTION 1A: PERSONAL AND FAMILY HISTORY OF ALL LIVES TO BE INSURED

It is important to answer all questions truthfully. Failure to disclose material information could result in non-payment of claim.

Personal Medical Details: Please answer the questions given below by tick marking against Yes or No.

A. Do you or any other Life to be Insured currently suffer or have ever suffered from high blood pressure, diabetes, cancer, chest pain, heart disorder, joint disorder or any liver or kidney disorder? ☐ Yes ☐ No

B. Do you or any other Life to be Insured currently suffer or have ever suffered from any other chronic medical ailment or have any physical deformity or handicap of any kind? ☐ Yes ☐ No

C. In the last 5 years, have you or any other Life to be Insured been hospitalised, undergone a surgery or taken treatment for a continuous period exceeding 7 days? ☐ Yes ☐ No

D. In the last 6 months, have you or any other Life to be Insured experienced any recurring health problem or undergone any medical investigation other than routine health checks? ☐ Yes ☐ No

E. Has your or any other Life to be Insured's Proposal for issuance or application for reinstatement for Life, Health or Accident Insurance ever been declined, postponed, withdrawn, accepted at extra Premium or subjected to any special terms? ☐ Yes ☐ No

F. Have you or any other Life to be Insured ever made a claim on any Health Policy including any employer paid Group Policy? ☐ Yes ☐ No

If you have answered Yes to A, B, C and D, please provide Additional Details in section 1B. Also provide relevant copies of hospital reports, consultation and investigation reports for the medical condition, if available.
If you have answered Yes to E, please provide Additional Details in section 1C.
If you have answered Yes to F, please provide Additional Details in section 1D.

☐ Section 1B: Additional Details (If you have answered Yes to A, B, C and D in section 1A above)

Insured Name (s)		
Relevant question no. from Section 1A		
Name of ailment/condition, nature of symptom(s)		
Date first diagnosed/treated or symptom(s) identified		
Details of investigation(s) done (please include dates)		
Details of past and current treatment (please include dates)		
Whether fully cured, recovered or still undergoing treatment?		
(Please attach a separate sheet in case the space is inadequate)		

Section 1C: Additional Details (If you have answered Yes to E in section 1A above)
Please tick ☑ where applicable

Insured Name	P	EP	SP	W	D	Name of Insurer	Reason / Description	Policy No (if applicable)

P: Postponed **EP**: Accepted with Extra Premium **SP**: Accepted on other Special Terms **W**: Withdrawn **D**: Declined
(Please attach a separate sheet in case the space is inadequate)

Section 1D: Additional Details (If you have answered Yes to F in section 1A above)

Insured Name	Name of the Insurance Company where you have filed or intend to file a claim	Claim Amount (INR)	Date of Claim	Status of Claim	Reason for claim

(Please attach a separate sheet in case the space is inadequate)

DECLARATIONS & AUTHORISATIONS

Declaration & Authorisations on behalf of all persons proposed 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 authorised 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 HDFC Life Insurance Company ("Company") and that the Policy will come into force only after full receipt of the premium chargeable.
- I understand that all information provided in this proposal form/electronic proposal form ("Proposal Form") and any attachments are material to the Insurer's decision to provide this insurance, and that insurance will be provided, at the Company's sole discretion, in reliance upon the truth of such information.
- 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 consent to the Company or any of its authorized representatives 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 or 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 further consent and authorise the Company or any of its authorized representatives to seek medical information from any doctor/ hospital/ consultant/ insurer that I or any person proposed to be insured has attended or may attend in future concerning any disease or illness in respect to a particular claim.
- I further consent and authorise 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 agree to the Company taking appropriate measures to capture the voice log for all such telephonic transactions carried out by me, in accordance with procedures/regulations.
- I voluntarily give my consent to collect, process, receive, possess, store, deal or handle my/our sensitive personal data or information [as defined in the Information Technology (Reasonable security practices and procedures and sensitive personal data or information) Rules 2011 as amended from time to time], with/ from third parties/ vendors associated with the Company for various purposes and outsourced activities exclusively related to issuance/servicing/settlement of claim as required under the Policy.
- I hereby also declare that I have read and understood the product as described in the sales literature and the sales illustration. I have read the entire text, features, disclosures, exclusions, terms and conditions while applying for insurance
- I understand that any false declaration or misrepresentation may be liable for rejection of the Proposal Form or the contract of insurance shall be treated null and void from inception of the contract. Fraud/ misrepresentation/ misstatement/ forfeiture/ suppression of material facts would be dealt with in accordance with the provisions of Section 45 of Insurance Act 1938 as amended from time to time.

SIGN HERE

(Signature of Policyholder)

Place: _____ Date: DD/MM/YYYY

Name of Policyholder: _____

Declaration to be made by a third person:

The Policyholder has affixed his/her thumb impression/has signed in vernacular/has not filled the application. I hereby declare that the content of this application form has been explained to the Policyholder in _____ language and have truthfully recorded the answers provided to me. I further declare that the Policyholder has signed/affixed his/her thumb impression in my presence.

SIGN HERE

(Signature of the Declarant)

Declarant Name: _____

Declarant Address: _____

Date: DD/MM/YYYY Place: _____

NOTE

With reference to recent regulatory changes, please submit PAN or Form 60 (if you do not have a PAN) with HDFC Life with immediate effect. Pls update via My Account/service@hdfclife.com/022-68446530/HDFC Life branch. Ignore if submitted.

HDFC Life Insurance Company Limited (HDFC Life). CIN: L65110MH2000PLC128245. IRDAI Registration No 101.
Regd. Off: 13th Floor, Lodha Excelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai - 400 011.
Communication address: 14th Floor, Lodha Excelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai - 400 011.