URN: 101/ November19/Group Health Shield SMQ/V03

MEMBER INFORMATION FORM

[IMPORTANT NOTE: Any cancellation and alteration must be countersigned by Member.
Please do not Sign Blank Information Form]

Plan Name:	**HDFC Life Group Health Shield**				
Options:	**Benefit Option^** *(Please select your Benefit Option)*	**Benefit Description**		**Sum Insured (INR)**	**Premium (INR)**
	Option A	Daily Hospital Cash Benefit	☐		
	Option B	Surgical Benefit	☐		
	Option C	Critical Illness Benefit	☐		
	Option D	Critical Illness excluding Cancer Benefit	☐		
	Option E	Critical Illness excluding Cardiac Benefit	☐		
	Option F	Critical Illness excluding Cancer and Cardiac Benefit	☐		
	Option G	Cancer Cover	☐		
	Option H	Cardiac Cover	☐		
	Option I	Personal Accident Cover	☐		
	^Only one out of options (C), (D), (E) and (F) can be chosen. ; Cancer Cover Benefit option cannot be chosen with Option C and E ; Cardiac Cover Benefit cannot be chosen with Option C and D ;				

Total/Single Premium (INR)_____ __ Member Cover Term: 1 Year (Yearly Renewable) ☐ Credit Linked _____ months ☐
Premium Mode: << Single/ Annual / Half Yearly / Quarterly / Monthly >>

Particulars of Member: Mr/Mrs. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth/: dd/mm/yyyy/ Gender: M /F/Tg **Height** :_____ Cms **Weight**: ____Kgs
Address for Communication:_____
Mobile/ Telephone No._____ Email Id: _____
Name/Address/ Tel number of Family Physician: _____
_____
Nationality: _____ **Country of Residence**: _____
Occupation: _____Annual Income:_____ **Nature of Duties**: _____
Particulars of Legal Guardian (if Member is a minor)**:** Mr/Mrs.☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Date of Birth/Age(yrs): dd/mm/yyyy /____ Gender: M /F/Tg Relationship with Member _____

Nominee / Appointee Details:

	Name	Date of Birth	Gender	Contact No.	Relationship to
Nominee:		dd/mm/yyyy			*Member*
Appointee:		dd/mm/yyyy			*Nominee if nominee is below 18 yrs of age*

HEALTH DETAILS OF MEMBER (Not applicable incase only Personal Accident Benefit is chosen)	Yes	No
1. In the past 2 years have you – a) Chewed tobacco in any form b) Smoked beedi/ cigarettes • How many beedis / cigarettes do you smoke in a day on an average _____ c) Consumed more than 12 units of alcohol per week • How many units do you consume in a week on an average _____ (1 unit alcohol equals 30 ml of hard liquor / one pint of beer / half glass	☐ ☐ ☐	☐ ☐ ☐
2. In the past 5 years, have you consumed narcotics, e.g.: Heroin, Cocaine, Cannabis, LSD, Ganja or other habit forming drug?	☐	☐
3. Have any of two or more of your first degree relatives (father, mother, brother, sister) suffered from: a) Heart conditions at age less than 55 years? b) Cancer at age less than 60 years?	☐ ☐	☐ ☐
4. On medical / health grounds has any insurance application or proposal for life, health, accident or critical illness including renewal and reinstatement ever been declined, deferred, withdrawn or accepted on special terms?	☐	☐

5. Have you ever suffered from or are suffering from; or received / receiving treatment or advised to undergo treatment for any of the following conditions, diseases or impairments a. High Blood Pressure, chest pain or heaviness, heart attack, palpitations, heart murmur, rapid or irregular heart beats, breathlessness with or without mild/moderate exertion or any other heart related diseases b. Blood sugar, Cholesterol or Triglycerides higher than the normal laboratory range c. Cancer, tumor, lumps or nodules anywhere on the body or any abnormal growth or any hormonal disorders or disorders of the blood? d. Asthma, tuberculosis, or coughing of blood e. Recurrent cough, hoarseness of voice or difficulty in swallowing for a continuous period of 15 days? f. Stroke, blackouts, giddiness, persistent headache, head injury associated with unconsciousness/ vomiting/bleeding from the ear, tremors, dizzy or fainting spells, blurred or double vision, epileptic fits, paralysis, muscle weakness, loss of sensations or movement, depression or any mental disorder? g. Passing blood in the urine, stones of the urinary tract, repeated urinary infections, HIV infections and sexually transmitted diseases? h. Ulcers, vomiting of blood or passing blood in stools, liver cirrhosis, Hepatitis B, Hepatitis C infections, liver disease, gall bladder stones? i. Arthritis, bone disorders or deformities, any physical deformity ,or any other disease of the bones and muscles? j. Weight loss of more than 5 kg (Other than targeted weight loss program) k. Unusual loss of blood or discharge from any body opening? l. Any disorder of the uterus, ovaries and other reproductive organs (For female applicants only)	☐	☐
6. During the last 5 years have you had any abnormal finding or adverse test report for any investigations like ECG ,Stress Test, 2D Echocardiography, Stress Thalium, Angiography, X-Ray / Ultrasound / CT / MRI scans, Endoscopy/ Colonoscopy, Biopsy, kidney and liver Function tests, PAP Smear, mammography, or any tests for diagnosis of cancer / heart conditions	☐	☐
7. Do you currently have or in the past 5 years had any medical condition, illnesses, diseases, disorders, disability, surgery or treatment which required you to be absent from work for at least 7 consecutive days or admitted in hospital for at least 5 consecutive days or sought Out Patient treatment (OPD) for more than 15 days.	☐	☐
8. Are you suffering from any congenital condition, disease or deformity?	☐	☐

Declaration & Authorization:

 I hereby declare that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge.

 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 HDFC Life Insurance Company Limited (**"Company"**) and that the policy will come into force only after full receipt payment of the premium chargeable.

 I understand that all information provided in this proposal form and any attachments are material to the insurer's decision to provide this insurance, and that insurance will be provided, at the insurer'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 my life after the proposal has been submitted but before communication of the risk acceptance by the Company.

 I declare and I consent to the Company seeking medical information from any doctor or from a hospital who at anytime has attended me or from any past or present employer concerning anything which affects my physical or mental health and seeking information from any insurance company to which an application for insurance has been made for the purpose of underwriting the proposal and/or claim settlement.

 I further consent and authorize the Company or any of its authorized representatives to seek medical information from any doctor/hospital/consultant/insurer that I have attended or may attend in future concerning any disease or illness or injury in respect to a particular claim.

 I authorize the Company to share information pertaining to my proposal including my 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 have voluntarily given my consent to collect, process, receive, possess, store, deal or handle my 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 products 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 & void from inception of the contract. Fraud, misrepresentation/ misstatement, or suppression of material fact would be dealt with in accordance with provisions of Section 45 of the Insurance Act 1938 as amended from time to time.

Signature / Thumb Impression of the Member
Name & Address_____
Occupation_____ Date & Place: _____

Declaration to be made by a 3rd person where: a) The Member has affixed his/her thumb impression; OR b) The Member has signed in vernacular; OR c) The Member has not filled the application.
I hereby declare that I have explained the contents of this application form to the Member in _____language and have truthfully recorded the answers provided to me. I further declare that the Member has signed/affixed his/ her thumb impression in my presence.

Signature of the Declarant Address of the Declarant_____
Name of the Declarant_____ Occupation of the Declarant_____ Date & Place_____

Signature of the Witness* Address of the Witness_____
Name of the Witness_____ Occupation of the Witness_____ Date & Place_____
* Witness Signature, Address and Occupation is required along with signature of Member

Declaration made by Member: I hereby declare that the content of the form and document has been fully explained to me and I have fully understood the significance of the proposed contract.

Signature/ Thumb expression of the Member

Declaration made by Legal Guardian if Member is a minor: I hereby declare that the content of the form and document filled up by the Member is accurate and true to my knowledge.

Signature / Thumb Impression of the
Legal Guardian (if Member is a Minor)

Note: PLEASE DO NOT SIGN BLANK ENROLLMENT FORM