

## URN: 101 /November 19/Regulated Merged DOGH/V03

## MEMBER INFORMATION FORM

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

Plan:		☐ HDFC Group Term Insurance Plan			Life Group	□ Н	☐ HDFC Life Group Credit Protect Plus				
				Credit Protect							
Option:		Accidental Death Benefit	N.A.		☐ Life Op	☐ Life Option ☐ Extra Life Option					
		Total Permanent Disability					☐Terminal Life Option				
		Total Permanent and Partial D	isability Benefit				Life Option 1				
		☐HDFC Life Group Critical II	ness Plus Rider			☐ Critical	Life Option 3	□Critica	l Life Option 4		
						☐ Life Di	sability Option				
Sum Assured (INR) Premium (INR) Policy Term (months) Moratorium Period (months)    Main benefit: Interest Rate:   Moratorium Period (months)											
Plan Name:	HDEC Life Crown Health Shield										
		Benefit Option^ (Please   Select your Benefit Option)   Sum Insu				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								
Options:		Option E	Critical Illness excluding Cardiac Benefit								
		Option F	Critical Illness exc								
		Option G	Cancer Cover								
		Option H	Cardiac Cover								
		Option I	Personal Accident Cover				1 1100	C 1	F G !: G		
		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 >>											
Particular	rs of	Member: Mr/Mrs.									
Date of Bi	rth/·	dd/mm/yyyy/ Geno	ler M /F/To Height	t · Cms		Weight:K	gs				
Address fo	or Co	ommunication:	<u></u>	· c		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
Mobile/ Telephone No. Email Id:											
Name/Address/ Tel number of Family Physician:											
Nationalit	hw7+			Country of	Docidoneo:						
Occupation	Nationality: Country of Residence: Cocupation: 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.	R	Relationship to			
Nomine	ee:			dd/mm/yyyy	<u>y</u>		Member				
Appointe	ee:			dd/mm/yyyy			Nominee if no	ominee is	below 18 yrs of		
								age			
Declaration of Good Health:											

I declare that I am in a sound state of health and as on the date of this declaration:

I confirm that I have never had or currently have chest pain, high blood pressure, heart attack or any other disease of the heart or circulatory system, stroke, transient ischaemic attack or any disease of the cerebrovascular system, asthma, tuberculosis or any other lung disorder, cancer, tumor / lumps of any kind, increased blood sugar, diabetes or any other disease of the endocrine system, increased cholesterol, any blood disorder, hepatitis or other liver disorders, genitourinary or kidney disorders, mental or nervous disorder, musculoskeletal disorders, HIV infection, a positive HIV antibody ("AIDS") test or AIDS Related Complex (ARC), coughing / vomiting of blood, stones in the kidney or gall bladder, joint pains, arthritis, weight loss of more than 5 kg in six months (other than through a targeted weight loss program), paralysis, disabilities / deformities, digestive and bowel disorders, any disorders of bone, spine or muscle or any other disease, disorder or disability not mentioned above excluding minor ailments such as cough and cold.

I confirm that I have not had any abnormal or adverse finding in any tests for cancer or heart conditions.

I confirm that I am not currently suffering from any disease or a change in health conditions for which I am planning to see a doctor or get myself investigated or undergo any surgical procedure.

In the past 5 years I have not had any medical condition, illnesses, diseases, disorders, disability, surgery or treatment which has required me to be absent from



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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... I confirm that I am not suffering from any congenital condition, disease or deformity I confirm that on medical / health grounds none of my insurance proposal for Life, Health, Critical Illness or Accident insurance has ever been declined, deferred, withdrawn or accepted on special terms. I do not participate or intend to participate in any dangerous sports such as mountaineering, motor racing, scuba diving, parachuting, or flying except as a paying passenger on a commercial flight or in any business or occupation of a hazardous nature I do not have any history of conviction under any criminal proceedings in India or abroad For Female Applicants only: I further declare that presently I am not pregnant or I do not have a history in the past of an abortion, miscarriage or caesarian section due to complications during pregnancy or due to any other cause, I have not given birth to a child with any congenital disorder such as Down Syndrome, congenital heart disease, etc and I have not ever had any disease of breast, uterus, cervix, ovaries or any other part of the reproductive system Currently I am in good physical and mental health. Signature/Thumb Impression of Scheme Member \_ Name & Address\_ Date & Place I do hereby declare that I have received a loan from M/s ("Master Policyholder"). In order to secure the said loan I have taken the above referenced policy from HDFC Standard Life Insurance Company Limited ("HDFC Life"). In consideration of receiving the said loan I hereby authorize HDFC Life to make payment of Outstanding Loan Balance amount to Master Policyholder by deducting from the claim proceeds payable on happening of the contingent event covered by the Group Life Insurance Scheme/ Policy referenced above. Signature/Thumb impression of Witness\* Signature / Thumb Impression of the Insured Member Name & Address Occupation Date & Place: \_\_\_ \* Witness Signature, Address and Occupation is along with signature of Insured Member **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 Standard 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



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Name & Address						
Occupation	Date & Place:					
	The Member has affixed his/her thumb impression; C	OR b) The Member has signed in vernacular; OR				
	of this application form to the Member insigned/affixed his/ her thumb impression in my presence.					
Signature of the Declarant	Address of the Declarant					
Name of the Declarant						
Signature of the Witness*	Address of the Witness					
Name of the Witness	Occupation of the Witness					
* Witness Signature, Address and Occupation is requi	ired along with signature of Member					
<b>Declaration made by Member:</b> I hereby declare the significance of the proposed contract.	hat the content of the form and document has been fully	y explained to me and I have fully understood the				
		Signature/ Thumb expression of the Member				
Declaration made by Legal Guardian if Member is and true to my knowledge.	s a minor: I hereby declare that the content of the form an	nd document filled up by the Member is accurate				
		Signature / Thumb Impression of the Legal Guardian (if Member is a Minor)				

Note: PLEASE DO NOT SIGN BLANK ENROLLMENT FORM