

URN: 101 / November 19/Regulated Merged SMQ/ V03

☐ HDFC Life Group Credit Protect Plus

MEMBER INFORMATION FORM

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

☐ HDFC Life Group

Credit Protect

Plan:

☐ HDFC Group Term Insurance Plan

Nominee / A Nominee: Appointee 1. If a) C b) S c) C 2. If ju 3. If a b 5. If	DETAILS OF MEMBER (Not app In the past 2 years have you — Chewed tobacco in any form Smoked beedi/ cigarettes How many beedis / cigarettes de Consumed more than 12 units of alco How many units do you consum (1 unit alcohol equals 30 ml of 10 Do you take part in any adventurous samping, etc.) In the past 5 years, have you consumed Have any of two or more of your first) Heart conditions at age less than	Da dd	n an average age f beer / half glas paragliding, m in, Cocaine, Ca r, mother, broth	ss wine) ountaineering, d nnabis, LSD, Ga	contact No. sen) eep sea diving , nja or other hab ed from:	Relationsi Memb Nominee if nominee is to motor racing, bungee it forming drug?	er	No O
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Nominee: Appointee	Appointee Details: Name	Da <u>dd</u> <u>dd</u>	ate of Birth //mm/yyyy	Gender	Contact No.	Relations Memb	er below 18 yr:	s of age
Nominee / A	Appointee Details: Name	Da dd	ate of Birth			Relations Memb	er	s of age
Nominee / A	Appointee Details:	Da	ate of Birth			Relations		
			_	Member				
Dute of Dire	th/Age(yrs): dd/mm/yyyy / G	elidel. <u>Wi /I/ I g</u> Rei	ationsnip with	Member				
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								
Occupation Particulars	:A	Annual Income:		Nature of I	outies:			
Nationality:	:		Country of l	Residence:				
Name/Addr	ress/ Tel number of Family Physici	an:						
Mobile/ Tele	Communication:ephone No		Email Id:					
Date of Birtl	n/: dd/mm/yyyy/ Gen	der: M /F/Tg Height:	Cms	V	/eight:Kgs			
Particulars	of Member: Mr/Mrs.							
_	ode: << Single/ Annual / Half Yearl							
Total/Single	Premium (INR)		: 1 Year (Yearly	y Renewable) \square	Credit Linked _	months 🗆		
	*Nonly one out of options (C), (D), Benefit cannot be chosen with Op		osen.; Cancer	cover Benefit of	nion cannot be c	nosen wun Option C and	ı E ; Caraia	ccover
	Option I ^Only one out of options (C), (D),	Personal Accident Co		Canan Banafit as		hosen with Ontion Con	l E . Candia	a Causa
	Option G Option H	Cancer Cover Cardiac Cover						
	Option F	Critical Illness exclud	ding Cancer and	d Cardiac Benefi	t \Box			
Options:	Option D Option E		Critical Illness excluding Cancer Benefit Critical Illness excluding Cardiac Benefit					
	Option C	Critical Illness Benefit						
	Option A Option B	Daily Hospital Cash Benefit □ Surgical Benefit □						
	select your Benefit Option)	Delle Hand 1 C. 1	Benefit Desc	cription	ΙП	Sum Insured (INR)	Premium	(INK)
Name:	Benefit Option^ (Please							
Plan			HDFC Life G	roup Health Sh	ield			
	le	evel / decreasing		for decreasing	option			
	Main benefit:	Interest	Rate: ⊔⊔9	%				
	ed (INR)P	remium (INR)	P	olicy Term (m	onths)	Moratorium Perio	od months)	
Sum Accur					•	sability Option		
Sum Accur	☐ Hotal Permanent and Partial Disability Be				☐ Critical	Life Option 3 □Criti		
		☐Total Permanent Disability☐Total Permanent and Partial Disability Benefit			☐ Terminal Life Option☐ Critical Life Option 1☐ Critical		cal Life Option 2	
	☐Total Permanent and Partial I		N.A.		☐ Life Op		a Life Opti	-



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6.	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?			
7.	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 cyst or any hormonal disorders or disorders of the blood (Anemia) or any endocrine disorder? d. Asthma, tuberculosis, coughing of blood or any other lung disorder? 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/disorder of brain & nervous system 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 psychiatric or mental disorder? g. Passing blood in the urine, stones of the urinary tract, repeated urinary infections, any other kidney disorder, HIV/AIDS 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 or any other disease of the stomach, pancreas, gall bladder and intestine? i. Arthritis, bone disorders or deformities, any physical deformity, or any other disease of the bones and muscles or any physical disability? j. Weight loss of more than 5 kg (Other than targeted weight loss program) Unusual loss of blood or discharge from any body opening?			
8.	For Female Lives: (a) Are you presently pregnant? (b) Do you have a history in the past of an abortion, miscarriage or caesarian section due to complications during pregnancy or due to any other cause? (c) Have you given birth to a child with any congenital disorder such as Down Syndrome, congenital heart disease, etc? (d) Have you ever had any disease of breast, uterus, cervix, ovaries or any other part of the reproductive system?			
9.	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			
10.	10. 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.			
11.	Are you taking any medication or has a doctor ever attended to you for any conditions, diseases or impairment not mentioned above			
12.	12. Do you have any history of conviction under any criminal proceedings in India or abroad?			
13.	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 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
\Box 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.
\Box 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.
\square 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.
\Box 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.



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\Box 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.						
\Box 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.						
	may be liable for rejection of the proposal form or the contract of insurance shall be treated null & misstatement, or suppression of material fact would be dealt with in accordance with provisions of time.					
Signature / Thumb Impression of the Member Name & Address	D. t. & Dis					
Occupation	Date & Place:					
I do hereby declare that I have received a loan from M/s						
Signature / Thumb Impression of the Member Name & Address Occupation	Date & Place:					
c) The Member has not filled the application.	nber has affixed his/her thumb impression; OR b) The Member has signed in vernacular; OR blication form to the Member inlanguage and have truthfully recorded the answers fixed his/ her thumb impression in my presence.					
Signature of the Declarant Name of the Declarant	Address of the Declarant Occupation of the Declarant Date & Place					
Signature of the Witness* Name of the Witness* Witness Signature, Address and Occupation is required along	Address of the Witness Date & Placewith signature of Member					
Declaration made by Member: I hereby declare that the consignificance of the proposed contract.	ntent of the form and document has been fully explained to me and I have fully understood the					
	Signature/ Thumb expression of the Member					
Declaration made by Legal Guardian if Member is a minor: accurate and true to my knowledge.	I hereby declare that the content of the form and document filled up by the Member is					
	Signature / Thumb Impression of the Legal Guardian (if Member is a Minor)					

Note: PLEASE DO NOT SIGN BLANK ENROLLMENT FORM