PSRF123031101309 / Comp/Oct/Int/2829

Policy Servicing Request Form- Health Plans - 2 (Please fill a separate form for each Request)	*For Official Use Only* Branch Name: Receipt Date & Time: Received by: Interaction ID:

Policy Number: ____________ Email ID *: ____________

Policyholder's name: (First Name) ____________ (Middle Name) ____________ (Last Name) ____________

Contact* No.: (Off) ____________ /(Res) ____________ / (Mob) ____________ (Mobile number is preferred)

* Contact details provided herein will be updated for all future communications. For the customers registered under National Do Not Call Registry, this response will be treated as valid discharge. Policy servicing charges may be levied as applicable. Please refer to your Policy document for details.

☐ ADDITION OF MEMBER (Please fill the attached SMQ)

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, & marriage. 3. All time bound exclusions and waiting period shall apply to such added members. 4. Addition of member is subject to underwriting approval. 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 & adoption are to be submitted where applicable.

I would like to add the below person as new member to be insured for 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 ☐ Post Graduate ☐ Others ____________

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

If Salaried specify Company Name: ____________ Designation: ____________ Contact No.: ____________

If self employed specify business /occupation: ____________

☐ CONVERSION OPTION

General Rules:

1. This option is available to only "Family Floater" plans. 2. This option can be exercised only when one of the minor life insured has attained majority. 3. New Policy will be issued without any underwriting requirements up to the sum insured as per the old Policy, provided there is no alteration by Policyholder in old Policy. 4. Any request for addition of a new member in the converted Policy will be subject to underwriting.

I ____________ a member life insured in the above Policy would like to opt for a new Policy as I have attained majority.

I ____________ Policyholder of the above Policy hereby consent for the above request and confirm that I have no objection whatsoever in this regard.

Signature of Policyholder: [SIGN HERE] Signature of Life Insured: [SIGN HERE]

☐ DELETION OF MEMBER

General Rules:

1. Deletion of member is permitted only at specific events like death & divorce of a life insured. 2. Attested copy of Death certificate or Divorce Agreement, as the case may be, has to be submitted for deletion of member. 3. The revised premium (if any) will be applicable from next premium due date.

I would like to delete the below life insured from my above Policy. Name: ____________

Date Of Birth: DD/MM/YYYY Sex: ____________ Reason for deletion: ____________

Date of Divorce: ____________ Date of Death: DD/MM/YYYY

HDFC Standard Life Insurance Company Limited. In partnership with Standard Life Plc. CIN:U99999MH2000PLC128245. IRDAI Registration No. 101.
Regd. Off: Lodha Excelus, 13th Floor, Apollo Mills Compound, N. M. Joshi Marg, Mahalaxmi, Mumbai - 400 011.

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

Policy No: ____________ Interaction ID No: ____________ Policyholder name: ____________

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

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

For queries or more information, call us on **1860-267-9999** (Local charges apply). DO NOT prefix any country code e.g. +91 or 00. Available all days from 9 am to 9 pm | Email - **service@hdfclife.com** |**NRIservice@hdfclife.com** (For NRI customers only) | Visit - **www.hdfclife.com**

Branch Stamp

Note: SMQ to be filled only for Addition of Member and Conversion Options.

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

SECTION 1A: PERSONAL AND FAMILY HISTORY OF ALL LIFE 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 below mentioned questions 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 any claim on any health Policy including any employer paid group Policy? ☐ Yes ☐ No

If you have answered Yes to Qn No. A, B, C and D above, please provide Additional Details in section 1B. Also provide relevant copies of hospital reports, consultation and investigation reports for medical condition, if available.
If you have answered Yes to Qn No. E above, please provide Additional Details in section 1C.
If you have answered Yes to Qn No. F above, please provide Additional Details in section 1D.

☐ Section 1B: Additional Details (If you have answered Yes to Qn No. 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 incase the space is inadequate)

Section 1C: Additional Details (If you have answered Yes to Qn No. E in section 1A above; Please tick ☑ where applicable

Insured Name	P	EP	SP	W	D	Name of Insurer	Reason / Description

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

Section 1D: Additional Details (If you have answered Yes to Qn No. F in section 1A above)

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

(Please attach a separate sheet incase the space is inadequate)

DECLARATIONS & AUTHORISATIONS

Declaration & Authorisations on behalf of all persons proposed to be insured

- I/We 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 o f my knowledge and that I/We am/are authorized to propose on behalf of these other persons.
- I understand that the information provided by me will form the basis o f the insurance Policy, is subject to the Board approved underwriting Policy of the insurance 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 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/We further declare that I/we will notify in writing any change occurring in the occupation or general health o f the life to be insured/proposer after the proposal has been submitted but before communication o f the risk acceptance by the company.
- I/We declare and consent to the company 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/We authorize 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 HDFC Standard Life Insurance Company Ltd. taking appropriate measures to capture the voice log for all such telephonic transactions carried out by me, in accordance withprocedures/regulations.
- 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.

Place__________________ Signature of Proposer [SIGN HERE]

Date DD/MM/YYYY Name of Proposer__________________

Declaration to be made by a third person where:

The Annuitants/ Purchaser have affixed his/her thumb impression; OR the Annuitants/ Purchaser has signed in vernacular; OR the Annuitants/ Purchaser has not filled the application. I hereby declare that I have explained the contents of this application form to the Annuitants/ Purchaser in __________________language and have truthfully recorded the answers provided to me. I further declare that the Annuitants/ Purchaser have signed/affixed his/her thumb impression in my presence.

Declarant Name:__________________ Date: DD/MM/YYYY Signature: [SIGN HERE]

DECLARATION

I hereby declare that the information provided above is true and correct to the best of my knowledge and belief. I confirm having read and understood all the terms and condition mentioned above.

Date: DD/MM/YYYY

Place:__________________

[SIGN HERE]
Signature of Policyholder