

HDFC LIFE GROUP CREDIT PROTECT PLUS INSURANCE PLAN
FOR OFFICE USE ONLY

Bank Name	Bancassurance Code	LG Code	Lead Ref Number
Group Joining Date	Member's Group Reference No.	Member ID	Proposal No
Consultant Name	Consultant Code	Lead Ref No	
Cheque Amount	Cheque No.	Promo	Single Premium (Rs)
Team/BR Code	LG/DSE	LC1 Code	LC2 Code

INSURED MEMBER INFORMATION FORM (FULL UNDERWRITING)

LOAN DETAILS

Loan account type		Loan account number	
Loan amount		Moratorium period (up to 7 years)	
Loan term (including moratorium period, if any)		Loan interest rate (%)	Share of the loan (%)
Date of first disbursement	DD/MM/YYYY		

SECTION A PLAN DETAILS

Cover Option (Main Benefit) <input type="checkbox"/> Level <input type="checkbox"/> Decreasing	Cover term _____ years	Initial Sum Assured _____	
Cover type <input type="checkbox"/> Single life cover <input type="checkbox"/> Joint life cover			

PLAN OPTIONS

<input type="checkbox"/> Life Option	Death benefit
<input type="checkbox"/> Extra Life Option	Death benefit + Additional Accidental death benefit
<input type="checkbox"/> Terminal Life Option	Death benefit + Accelerated Terminal Illness benefit
<input type="checkbox"/> Critical Life Option 1	Death benefit + Accelerated Critical Illness benefit – Lower of 5 years or death benefit term
<input type="checkbox"/> Critical Life Option 2	Death benefit + Accelerated Critical Illness benefit – Lower of 10 years or death benefit term
<input type="checkbox"/> Life Disability Option	Death benefit + Accelerated Total Permanent Disability

SECTION B PERSONAL DETAILS OF INSURED MEMBER

Affix recent photograph of life to be assured Photograph to be signed across by the life to be assured	Name Title / Mr. /Mrs. Surname First Name Middle Name			
	Maiden name (only for married females)	DOB DD/MM/YYYY		
	Place of Birth	Nationality		
Full name of father/spouse Title / Mr./Mrs. Surname First Name Middle Name				
Are you an existing life assured, assignee, proposer of any of our plan: Yes <input type="checkbox"/> No <input type="checkbox"/>				
If "Yes" Please provide the Policy/Proposal number(s):				
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Marital status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>		
Educational qualifications: HSC <input type="checkbox"/> Graduation <input type="checkbox"/> Post graduation <input type="checkbox"/> Others:				
Nature of documents of age proof attached:			Visible marks of identification:	
Mailing address (The address where you wish to receive documents and other communications) : Your preferred mode & Language of communication Language _____				
			Home <input type="checkbox"/> Workplace <input type="checkbox"/>	
			<input type="checkbox"/> SMS <input type="checkbox"/> Email <input type="checkbox"/> Tele Calls <input type="checkbox"/> Letter/ Mail	

passenger), mountaineering, deep sea diving or any form of racing. Yes No

If you have answered "Yes" to the above question, please give details below:

4) Have you resided overseas for more than 6 months continuously during the last five years, or do you intend to do so in the next six months? Yes No

If you have answered "Yes" to the above question, please give the names of the countries and duration of stay:

	Name of Countries	Duration
Past Travel		
Future Travel		

5) Do you have any existing insurance cover or have you submitted any simultaneous applications for life insurance to any other insurance company?

Yes No

If "yes" please provide the following details:

(All amounts in Rupees)

A. Sum Assured payable on death (total)	
B. Sum payable on accidental death (excluding A)	
C. Benefits payable on disability/critical illness	
D. How much of this cover i.e. (A) + (B) + (C) was taken out in the last 12 months?	
E. How much of the cover in (A) was taken out during the last five years?	

6) Has any application for insurance on your life been:

	Yes	No
Postponed?	<input type="checkbox"/>	<input type="checkbox"/>
Accepted with extra premium?	<input type="checkbox"/>	<input type="checkbox"/>
Accepted on other special terms?	<input type="checkbox"/>	<input type="checkbox"/>
Declined?	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawn by yourself?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes" to any of the above questions, please state the proposal number, name of the insurance company and reason.

7) State your height and weight as accurately as possible.

Height: _____ Cms (or) _____ Feet ____ Inches Weight: _____ Kgs

8) Please indicate if you consume any of the substances mentioned below:

Substance	Do you consume?		Form of consumption (Tick where applicable)				Quantity consumed
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Beer <input type="checkbox"/>	Wine <input type="checkbox"/>	Spirits <input type="checkbox"/>	Others <input type="checkbox"/>	
a. Alcohol*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Per Week _____ Units
b. Tobacco**	<input type="checkbox"/>	<input type="checkbox"/>	Cigars <input type="checkbox"/>	Cigarettes <input type="checkbox"/>	Bidis <input type="checkbox"/>	Chewing Tobacco <input type="checkbox"/>	Per Day _____ Units
c. Are you currently consuming or have you ever consumed narcotics or any such other substance whether prescribed or not? (For example ganja, hashish, heroin, cocaine, charas, marijuana etc.)							<input type="checkbox"/> Yes <input type="checkbox"/> No

* 1 unit equivalent to 330 ml of beer/ 125 ml of wine/ 30 ml of spirits ** 1 unit equivalent to 1 cigar/1cigarette/1 bidi. If chewing tobacco please specify how many grams per day.

9) State the name and address of your doctor whom you usually consult in the event of any illness, or if you have been consulting with this doctor for less than three months, then the name and address of your previous doctor.

Name			
Address			
STD		Telephone	
Mobile		Email	

10) Personal medical details.

1	Are you currently in good health?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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2	Do you have / had any recurrent medical condition or physical disability or deformity or illness or injury Or have you been hospitalized or operated or asked to undergo investigations that has kept you from working for more than one week in the last 5 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	Have you ever tested positive for HIV/AIDS or Hepatitis B or C, or have you been tested/treated for other sexually transmitted diseases or are you awaiting the results of such a test?	Yes <input type="checkbox"/> No <input type="checkbox"/>

11) Please tick the appropriate answer to **all** of the questions below:

Have your ever had, been told to have, or been treated for: (a)Diabetes, High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) Chest pain, heart attack or any other heart disease or disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Cancer, tumor, growth or cyst of any kind	Yes <input type="checkbox"/> No <input type="checkbox"/>
(d) Stroke, paralysis, Epilepsy, any psychiatric/mental disorder, disorders of brain/ nervous system or any kind of physical disabilities.	Yes <input type="checkbox"/> No <input type="checkbox"/>
(e) Asthma, Tuberculosis or any other lung or respiratory disorder.	Yes <input type="checkbox"/> No <input type="checkbox"/>
(f) Disease or disorder of muscles, bones or joints; arthritis, blood disorder (e.g. anaemia), thyroid disorder or any endocrine disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
(g) Disease or disorder of the kidney, urinary system, digestive system (stomach, pancreas, gall bladder, intestines), liver, Hepatitis B or C or HIV / AIDS infection, or any sexually transmitted disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
(h) Disease or disorder of the Eye, Ear, Nose or throat	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you have answered "Yes" to any of the sub questions asked under question 11 of this section, please answer the following

Nature of Illness/ Accident	Date of Diagnosis/ Event	Name & Address of the doctor	Details of Investigations done	Under Medication (Yes/ No)	Fully Recovered (Yes/ No)

12) To be answered by the female life to be assured. Please tick the appropriate answer to **all** of the questions below.

(a) Are you presently pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) If "Yes", how many weeks ? Kindly attach the Pregnant Lady Questionnaire	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Have you ever had any disease of the breast, uterus, cervix, or ovaries?	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you have answered "Yes" to (c) please give details below:

13) Family history of the life to be assured. Please tick the appropriate answer to **all** of the questions below:

Have any of your parents and/or siblings died before the age of 60 years as a result of Blood pressure, heart attack, stroke, cancer, diabetes, Kidney disease or any hereditary disorder? Yes No

If you have answered "Yes" to any of the above questions, please give details below:

Relation to Life to be Assured	Disease	Age at diagnosis	Alive / Dead	Current age / Age at Death

SECTION D DETAILS OF NOMINEE

Name (nominee 1):	DOB: DD/MM/YYYY
Address:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
	Relationship with Insured Member:
Telephone:	Email:
Name(nominee 2):	DOB: DD/MM/YYYY
Address:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
	Relationship with Insured Member:
Telephone:	Email:
In case Nominee is minor , please give Appointee details	
Name:	DOB: DD/MM/YYYY

Address:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
	Relationship to Nominee:

Signature of appointee accepting the appointment

SECTION E

DECLARATION OF INSURED MEMBER

I understand, agree and confirm that these statements and this declaration are basis of the contract between the insurer and the policyholder. If any untrue statement are contained herein or there has been any non disclosure of any material fact, the policy to be issued by the insurer in the name of the policyholder may be treated as void as far as I am concerned.

I confirm that I have read and understood, the rules and any additional rules of the HDFC Life Group Credit Protect Plus Insurance Plan, the standard Policy provisions and any additional provisions that govern the policy to be issued by insurer in the name of the policyholder and on my life, and I agree and confirm that the same shall be binding on me. I authorise the policyholder to disclose to the insurer such particulars as they may require including the details given above and any changes to the same pay the premium payable on my behalf /collected from me to the Insurer. I understand that any statutory levy or charges including any indirect tax may be charged to me either now or in future by the insurer and I agree to pay the same. I understand that HDFC SL has the right to reject a proposal without giving reasons thereto and client to give an undertaking thereof that he shall not raise any claims thereof. I understand the significance of the contract and the contract will be governed by the provisions of the Insurance Act 1938 and that the same will not commence until written acceptance of this application by Insurer issue on its normal terms and conditions is received.

DECLARATION MADE BY INSURED 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 impression of Witness* Name & Address _____ Occupation _____ <small>* Witness Signature, Address and Occupation is mandatory along with signature of Insured Member</small>	Signature / Thumb Impression of the Life to be Assured _____ Date & Place: _____
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Declaration to be made by a 3rd person where:
 —The insured member has affixed his/her thumb impression; OR
 —The insured member has signed in vernacular; OR
 —The insured member has not filled the application.

I hereby declare that I have explained the contents of this application form to the insured member in _____language and have truthfully recorded the answers provided to me. I further declare that the insured member has signed/affixed his/ her thumb impression in my presence.

Name and address of Declarant _____	Signature _____
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Date:

To
HDFC Standard Life Insurance Company Limited
Lodha Excelus, 13th Floor
Apollo Mills Compound, N.M. Joshi Marg
Mahalaxmi, Mumbai - 400 011.

Name of Policy Holder:

Contact Number: Mobile: _____/ Office: _____/ Res: _____

Loan Application / Account Number:

Group Life Insurance Scheme/ Policy Number:

DECLARATION/ AUTHORIZATION:

I/We, _____, do hereby declare that I/ we have received a loan of Rs _____ from M/s _____ (“Master Policyholder”). In order to secure the said loan I/ we 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.

Request you to kindly take note of the above mentioned request and update your records accordingly.

Thanking You,

With Regards,

(Member)