

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6					
3. Please specify the type of cardiac ailment you have been operated for <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">PTCA (Angioplasty)</td> <td style="width: 20%;">CABG</td> <td style="width: 20%;">Septal defect surgery(A SD/VSD)</td> <td style="width: 20%;">Radiofrequency ablation (RFA)</td> <td style="width: 20%;">Others</td> </tr> </table> Please mention date in DD/MM/YYYY format	PTCA (Angioplasty)	CABG	Septal defect surgery(A SD/VSD)	Radiofrequency ablation (RFA)	Others	Cardiac ailment _____ Date of surgery/ Procedure _____ Name of Surgeon/card iologist _____ Name of hospital with complete address _____ _____ _____	Cardiac ailment _____ Date of surgery/ Procedure _____ Name of Surgeon/card iologist _____ Name of hospital with complete address _____ _____ _____	Cardiac ailment _____ Date of surgery/ Procedure _____ Name of Surgeon/card iologist _____ Name of hospital with complete address _____ _____ _____	Cardiac ailment _____ Date of surgery/ Procedure _____ Name of Surgeon/card iologist _____ Name of hospital with complete address _____ _____ _____	Cardiac ailment _____ Date of surgery/ Procedure _____ Name of Surgeon/card iologist _____ Name of hospital with complete address _____ _____ _____	Cardiac ailment _____ Date of surgery/ Procedure _____ Name of Surgeon/card iologist _____ Name of hospital with complete address _____ _____ _____
PTCA (Angioplasty)	CABG	Septal defect surgery(A SD/VSD)	Radiofrequency ablation (RFA)	Others							
4. Have you experienced any below mentioned symptoms post undergoing above mentioned surgery/procedure I. Chest heaviness or Pain II. Difficulty in breathing III. Palpitations IV. Loss of consciousness V. Weakness or dizziness	Enter Option _____										
5. Have you been advised for any other/repeat procedure or admission? If yes please share details	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____										
6. Please share following documents, wherever applicable: Discharge summary/Investigation reports /Follow up records/Angiography report/CD/Latest ECHO, ECG, Stress test	Record name _____										
7. Hypertension / High Blood Pressure/ High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____										
8. Diabetes Mellitus / High Blood Sugar / Diabetes on medication	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____										
9. Smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs? If 'Yes' then please provide the frequency and amount consumed. • Hard Liquor (No. of Pegs in _____ per week) and Since _____ • Beer (Bottles/ml per week) and Since _____ • Wine (Glasses/ml per week) and Since _____ • Smoking (no. of Sticks per day) and Since _____ • Gutkha or Masala/Chewing Tobacco (Sweets/Grams per day) and Since _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____ _____ _____ _____ _____										
10. Apart from the cardiac ailment, have you ever been Diagnosed/Suffered/Treated with Medication for any of the following condition: If Yes, please provide details in additional information section below:	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____										
a) Cancer, tumor, polyp or cyst	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____										
b) Asthma / Tuberculosis / COPD/ Pleural effusion / Bronchitis / Emphysema or any other disease of Lungs, Pleura and airway or Respiratory disease	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____										
c) Thyroid disease/ Cushing's disease/ Parathyroid Disease/ Addison's disease / Pituitary tumor/ disease or any other disorder of Endocrine system	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____										
d) Motor Neuron Disease/ Muscular dystrophies/ Myasthenia Gravis or any other disease of Neuromuscular system (muscles and/or nervous system)	<input type="checkbox"/> Y <input type="checkbox"/> N Since _____										

Particulars	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
e) Stroke/ Paralysis/ Transient Ischemic Attack/ Multiple Sclerosis/ Epilepsy/ Mental-Psychiatric-illness/ Parkinsonism/ Alzheimer's/ Depression / Dementia or any other disease of Brain and Nervous System	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____					
f) Cirrhosis / Hepatitis / Wilson's disease / Pancreatitis / Liver disease / Crohn's disease / Ulcerative Colitis /Piles or any other disease of Mouth, Esophagus, Liver; Gall bladder; Stomach or Intestines or any other part of Digestive System	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____					
g) Kidney Stones/ Renal Failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract or reproductive organs	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____					
h) HIV/SLE/ Arthritis/ Scleroderma / Psoriasis/ bleeding or clotting disorders or any other diseases of Blood, Bone marrow/ Immunity or Skin	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____					
i) Disease or disorder of eye, ear, nose or throat (except any sight related problems corrected by prescription lenses	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____					
j) Has any of the Proposed to be Insured been hospitalized/ recommended to take investigation/medication or has been under any prolonged treatment/undergone surgery for any illness/injury other than for childbirth/minor injuries	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____					
k) Are you or anyone of your family member(1st blood relationship) suffering from any of the following conditions: Down's Syndrome/Turner's Syndrome/Sickle Cell Anaemia/ Thalassemia Major/G6PD deficiency	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____					
l) Any other disease / health adversity / injury/ condition / treatment not mentioned above	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____					

Note: The Company shall reject Your proposal and refund the premium amount (after deducting cost of medical tests, if any) in case of incompleteness or any discrepancy highlighted or any other reason.

Date : / / (DD/MM/YYYY)

Signature of the Proposer : _____

Place :

(On behalf of all the persons to be insured under the Policy)

ADDITIONAL INFORMATION (IF YOUR ANSWER IS 'YES' TO ANY OF THE ABOVE QUESTIONS OR THE PROPOSED TO BE INSURED ARE SUFFERING FROM ANY OTHER PRE EXISTING DISEASE WHICH IS NOT MENTIONED IN THE ABOVE LIST)

DETAILS OF PREVIOUS OR EXISTING HEALTH INSURANCE

Please fill the following details with respect to health insurance proposals/policies with the Company or any other insurance companies

Details	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5	Insured 6
Have any of the person(s) to be insured ever filed a claim with their current/previous insurer? If Yes, please provide details on a separate sheet	<input type="checkbox"/> Y <input type="checkbox"/> N					
Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium or issued with special condition(s)?	<input type="checkbox"/> Y <input type="checkbox"/> N					
Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company or any other Company without break?	<input type="checkbox"/> Y <input type="checkbox"/> N Since_____ (DD/MM/YYYY)					

STATUTORY WARNING

Prohibition of Rebates

(Under Section 41 of Insurance Act 1938)

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

DECLARATION FOR AGENTS

I _____ (Full Name) in my capacity as an Insurance Advisor/Specified Person of the Corporate Agent/ Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form basis of the Contract of Insurance between the Company and the Proposer; if this proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished to be furnished, the Company shall have the right to vary the benefits which may be payable as per Policy Terms and Conditions and furthermore, if there has been a non-disclosure of any material fact, the policy issued to his/her favor pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the Company.

License No. (Advisor/Corporate Agent/Broker/Relationship Officer):

Date : / / (DD/MM/YYYY)

Signature : _____

SP Name : _____

SP Code :

ADDENDUM – VERNACULAR DECLARATION

I _____, son/daughter of _____, resident of _____ declare that I have read out and fully explained the contents of the Proposal Form and all other accompanying documents in _____ language to the Proposer which is a language understood by him/her and is operative for the Proposer to avail the insurance from the Company. The contents and import of the proposal have been fully understood by him/her and the replies have been recorded accordingly. Information provided by the Proposer. The replies have also been read out to, fully understood and confirmed by the Proposer.

Date : / / (DD/MM/YYYY)

Place :

Name of the Declarant : _____

Signature of the Declarant : _____

(On behalf of all the Proposed to be Insured under the Policy)