

INDUSIND HEALTH SUPER TOP UP - PROPOSAL FORM

1. To be filled and signed by Proposer and all fields are mandatory to be filled.
2. This proposal shall be the basis of contract for Policy issuance.
3. IndusInd General Insurance Company Ltd. (the "Company") is under no obligation to accept any proposal for insurance. The liability of the Company does not commence until the proposal is accepted and underwritten by the Company and premium is received. If the Company accepts a proposal for insurance, it shall be subject to the Policy Terms and Conditions.

INTERMEDIARY DETAILS (To be filled in BLOCK LETTERS)			
Intermediary Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.		
Intermediary Code		IMD Branch Name	
IMD Employee Code			
PROPOSER'S DETAILS (To be filled in BLOCK LETTERS)			
Name of the Proposer	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.		
Permanent Address			
City		State	
Pin Code		Contact Number	
Permanent Address			
City		State	
Pin Code		Contact Number	
Primary No .		Seconday No.	
E-mail Id			
Date of Birth	DD / MM / YYYY	Nationality	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other
Maiden Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.		
Occupation	<input type="checkbox"/> Salaried <input type="checkbox"/> Self-Employed <input type="checkbox"/> Others, pls specify _____		
Source of Income	<input type="checkbox"/> Upto ₹ 20,000 <input type="checkbox"/> ₹ 20,001 to ₹ 50,000 <input type="checkbox"/> ₹ 50,001 to ₹ 1,00,000 <input type="checkbox"/> ₹ 1,00,001 and above		
Pan No			
Aadhar No	(Please fill at least one)		
GST Registration Number	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Nomination Details			
The nominee as declared hereunder shall become eligible for payment under the Policy as per the terms and conditions of the Policy, in the event of the death of the Policyholder. The receipt of proceeds by the nominee would be sufficient discharge to the Company. Nominee for all other person(s) proposed shall be the proposer himself/herself.			
Name of Nominee	D.O.B.	Relationship with Proposer	Address of Nominee
	DD / MM / YYYY		



POLICY DETAILS

- a. Plan Required A B
 - b. Cover Type: Individual Floater
 - c. PED Waiting Period Required 24 months 36 months
 - d. Policy Period Required* 1 Year 2 Years 3 Years Policy
- Start Date DD/MM/YYYY

*For Plan B Policy Period is available for 2 years or 3 years

Plan/Policy Details

Deductible (in lakhs)	Sum Insured (in lakhs)				
2	<input type="checkbox"/> 5	<input type="checkbox"/> 8	<input type="checkbox"/> 13	<input type="checkbox"/>	
3	<input type="checkbox"/> 7	<input type="checkbox"/> 12	<input type="checkbox"/> 22	<input type="checkbox"/> 47	
4	<input type="checkbox"/> 6	<input type="checkbox"/> 11	<input type="checkbox"/> 21	<input type="checkbox"/> 46	
5	<input type="checkbox"/> 5	<input type="checkbox"/> 10	<input type="checkbox"/> 20	<input type="checkbox"/> 45	<input type="checkbox"/> 95
6	<input type="checkbox"/> 9	<input type="checkbox"/> 19	<input type="checkbox"/> 44	<input type="checkbox"/> 94	
9	<input type="checkbox"/> 16	<input type="checkbox"/> 41	<input type="checkbox"/> 91	<input type="checkbox"/>	
10	<input type="checkbox"/> 15	<input type="checkbox"/> 40	<input type="checkbox"/> 90	<input type="checkbox"/>	
12	<input type="checkbox"/> 13	<input type="checkbox"/> 38	<input type="checkbox"/> 88	<input type="checkbox"/>	
15	<input type="checkbox"/> 35	<input type="checkbox"/> 60	<input type="checkbox"/> 85	<input type="checkbox"/>	
18	<input type="checkbox"/> 32	<input type="checkbox"/> 57	<input type="checkbox"/> 82	<input type="checkbox"/>	
20	<input type="checkbox"/> 30	<input type="checkbox"/> 55	<input type="checkbox"/> 80	<input type="checkbox"/> 130	
30	<input type="checkbox"/> 45	<input type="checkbox"/> 70	<input type="checkbox"/> 120	<input type="checkbox"/>	

PROPOSER'S BANK DETAILS (IN CASE OF REFUND)

Name of the Bank Account Holder Mr. Ms. Mrs. F I R S T M I D D L E L A S T

Bank Account No.: Account: Saving Current

Name of the Bank

Branch

MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)

IFSC Code (11 character code appearing on your cheque leaf)

I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.



Details of Person(s) Proposed to be Insured

Section A: Personal Details

Details	MEMBER1	MEMBER2	MEMBER3	MEMBER4
Name of the Insured Person				
Gender (M/F)				
Date of Birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Relationship with Policyholder				
Nationality				
Occupation				
Height (in cms.)				
Weight (in Kgs)				

DETAILS OF PERSON(S) PROPOSED TO BE INSURED

Section A: Personal Details

Details	MEMBER5	MEMBER6	MEMBER7	MEMBER8
Name of the Insured Person				
Gender (M/F)				
Date of Birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Relationship with Policyholder				
Nationality				
Occupation				
Height (in cms.)				
Weight (in Kgs)				

Medical Questions	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
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The following Medical questions are compulsory for each proposal. Where any of the below responses are positive (Yes), the list of PED questions shall be triggered.

Is any person proposed to be insured on (or prescribed to be on) regular medication (Medication prescribed for more than two weeks)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person proposed to be insured presently suffering (or suffered in the past 15 days) from any disease/illness/accident/injury other than common cold or fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is any person proposed to be insured been advised to undergo any investigation or further tests other than routine health check-up or pre-employment check-up or routine maternity checkup in last 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any person proposed to be insured, undergone any surgery in the last 3 years or is planned to undergo any surgery at present or in the near future?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was any person proposed to be insured diagnosed with any of these medical conditions with or without any follow-up tests/medications?								
• Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• High Cholesterol Or High Triglycerides	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Hypothyroidism Or Pituitary Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Liver Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Unexplained Weight loss (> 5kg) in Last 6 Months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Is Any Of The Insured Person Pregnant? If Yes, Please Mention The Date Of Delivery.	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of Delivery DD/MM/YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of Delivery DD/MM/YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of Delivery DD/MM/YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of Delivery DD/MM/YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of Delivery DD/MM/YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of Delivery DD/MM/YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of Delivery DD/MM/YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of Delivery DD/MM/YYYY
Has any application for health (or Mediclaim), hospital daily cash or critical illness insurance for any person proposed to be insured ever been:								
• Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Subject to Loading in premium due to health conditions or been made	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Subject to any special conditions by any insurance company	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
PED Questions	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
The following Medical questions are compulsory for each proposal. Where any of the below responses are positive (Yes), the list of PED questions shall be triggered.								
Has the person proposed to be insured suffered from (or undergone) any of the following illnesses/sickness/medical conditions/medical procedures during the past 3 years? (Yes/No, Date of First Diagnosis):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Chest Pain or Heart Attack or any ailment/ diseases/ surgery of the Heart or arteries or other blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung transplant, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis, Tuberculosis, Asthma, Bronchitis, breathing difficulties or disorder of the lung/ respiratory track requiring surgery or hospitalization within the past 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any sexually transmitted diseases including Syphilis, Gonorrhoea, Genital Herpes, Chlamydia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Cirrhosis, Alcoholic Liver disease, Oesophageal Varises and Fibrosis, Pancreatic Disease, Hepatitis B, Hepatitis C or any other disorder of the liver or pancreas, or Liver transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inflammatory Bowel Disease, Crohn's disease, Systemic Lupus Erythematosus or any other ailment of the digestive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, Leukemia, Papulosquamous disorder of skin, Tumor - malignant, or any growth or cyst anywhere in the body?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatoid arthritis, Avascular Necrosis, Ankylosing Spondylitis, Spinal Stenosis, Spondylosis, Multiple Sclerosis, Muscular Dystrophy or any other disorder of bone, muscles or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney transplant, Kidney/Renal Failure, Stone in urinary tract, Prostate disorder or any other kidney disorder whether or not requiring dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Stroke, Epilepsy (fits), Paralysis, Demyelinating disease, Alzheimers Disease, Parkinsons Disease or any other disorder of the brain, spinal cord or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Severe Anemia, Hemophilia, Idopathic Thrombocytopenia Purpura, Thalassemia (major), Peripheral Vascular Disease, Deep Vein Thrombosis, Lymphoma or any other blood/Lymphatic system disease or Sarcoidosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Obstructive Sleep Apnea, Diabetes with HbA1c >= 10 or fasting sugar above 250, Hypertension with three medication or blood pressure above 180/100?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebral Palsy, any internal deformity or sickness from birth / early childhood?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diseases of the Ear/ Nose/Throat/Teeth/ Eye (please mention Diopters in case of refractory error)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Detoxication therapy for alcohol, narcotics, or any other habit-forming drugs? Any other Illness/ Injury: Please Specify	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have ticked 'Yes' in any of the boxes above, please name the disease/condition here and specify since when are you suffering from such disease/condition.	1. Name Of Disease/ Condition 2. Since: DD/MM/YYYY	1. Name Of Disease/ Condition 2. Since: DD/MM/YYYY	1. Name Of Disease/ Condition 2. Since: DD/MM/YYYY	1. Name Of Disease/ Condition 2. Since: DD/MM/YYYY	1. Name Of Disease/ Condition 2. Since: DD/MM/YYYY	1. Name Of Disease/ Condition 2. Since: DD/MM/YYYY	1. Name Of Disease/ Condition 2. Since: DD/MM/YYYY	1. Name Of Disease/ Condition 2. Since: DD/MM/YYYY
Lifestyle Questions	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Does any of the persons proposed to be insured use tobacco products/ cigarettes or drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do any immediate family member (father, mother, brother or sister) of any of persons proposed to be insured have / had in the past: diabetes, hypertension, cancer, heart attack, or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Note: The Company may apply a risk loading upto 150% on the premium payable (based upon the declarations made in the Proposal form and the health status of the members proposed to be insured). These loadings would be applied from the first policy and its subsequent renewals with the Company.

Any loadings, if applicable, shall be suitably intimated to the Proposer based on the assessment of the Proposal form and/or medical tests. The Proposer shall be required to pay an additional premium within 7 days of such intimation.

The Company shall only be at any risk once it receives and accepts this additional premium. In the event of non-receipt of this additional premium within the stipulated time, Company shall cancel your proposal and refund the amount after deducting cost of medical tests, if any.

SECTION B: CURRENT/PREVIOUS HEALTH - INSURANCE DETAILS

Section B: Current/Previous Policy - Insurance details

Details	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Name Of Insurer:								
Policy No.								
Policy: Start Date	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Period: End Date	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Sum Insured (₹):								
Cumulative Bonus, if any Deductible limit and Type of Deductible applicable (Per Claim Basis or Aggregate Deductible)								
Type Of Cover:	<input type="checkbox"/> Individual <input type="checkbox"/> Floater	<input type="checkbox"/> Individual <input type="checkbox"/> Floater	<input type="checkbox"/> Individual <input type="checkbox"/> Floater	<input type="checkbox"/> Individual <input type="checkbox"/> Floater	<input type="checkbox"/> Individual <input type="checkbox"/> Floater	<input type="checkbox"/> Individual <input type="checkbox"/> Floater	<input type="checkbox"/> Individual <input type="checkbox"/> Floater	<input type="checkbox"/> Individual <input type="checkbox"/> Floater
Have any of the persons to be insured ever filed a claim with their current/previous insurer? If yes, please provide details on a separate sheet	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any proposal of life, critical or health insurance been declined, cancelled or charged a higher premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any of the persons proposed for insurance covered under any other health insurance policy with the Company?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you applying for portability? Yes No (If yes, please fill in the separate Portability Form)

PREMIUM PAYMENT DETAILS

Payment By: Cheque DD Credit Card Debit Card NEFT Net Banking

Cheque or DD Amount ₹ _____

Amount In Words: _____

Bank Name: _____

Cheque/DD/Card No: _____ Cheque/DD Date DD / MM / YYYY

Name of the Premium Payer: _____

*In case of payment made through Cheque / DD then please issue an A/c payee instrument in favour of "IndusInd General Insurance Company Limited"

#In case of payment made through Credit/ Debit Card the Card needs to be in the name of the Proposer

STANDARD DECLARATIONS & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED BE

- I 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 of my knowledge and that I authorized to propose on behalf of these other persons.
- 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 the insurer and that the policy will come into force only after full payment of the premium chargeable.
- I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured / proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- I declare and consent to the company seeking medical information from any doctor or hospital who/which at any time has attended on the person to be insured / proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured / proposer and seeking information from any insurer to whom an application for insurance on the person to be insured/ proposer has been made for the purpose of underwriting the proposal and / or claim settlement.
- I authorize the company to share information pertaining to my proposal including the medical records of the insured/proposer for the sole purpose of underwriting and / or claims settlement and with any Governmental and / or Regulatory authority.

Place: _____

Date: _____

Signature of Proposer/
Authorized Representative*

(*Only Applicable where proposer is a person with a disability and who has appointed an authorized representative.

Please specify name of Authorized representative _____)

OTHER DECLARATIONS & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- I consent to receive information from the Company through physical, electronic or telecommunication means from time to time
- I hereby state that the above-mentioned address shall be taken as address on record for the purpose of GST.
- I hereby confirm that the contents of the proposal form and connected documents have been fully explained to me/us and I have fully understood the significance of the proposed contract.
- I understand that the Policy shall become void at the Company's option, in the event of misrepresentation, mis-description or non-disclosure of any material fact in the Proposal form/personal statement, declaration and connected documents or any material information having been withheld by me or anyone acting on my behalf.
- I hereby declare that the person(s) proposed to be insured would submit to medical examinations, before the nominated doctors of the Company, or undergo diagnostic or other medical tests, as suggested by the Company for its underwriting.
- I consent to provide a valid age proof and identity proof at the time of claims or any other time when required by the Company.
- I agree and undertake to convey to the Company any change/alterations carried out in the risk proposed for insurance after submission of this Proposal form.

Place: _____

Date: _____

Signature

indusindinsurance.com 022 4890 3009 (Paid) 74004 22200 (WhatsApp)

IRDAI Registration No. 103. IndusInd General Insurance Company Limited.

An ISO 9001:2015 Certified Company

For complete details on the benefits, coverage, terms & conditions and exclusions, do read the sales brochure, prospectus and policy wordings carefully before concluding sale. Registered & Corporate Office: 6th Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai-400063. Corporate Identity Number: U66603MH2000PLC128300.

IndusInd Health Super Top Up. UIN: RELHLIP21617V012021. IGI/MCOM/CO/INDUSIND HEALTH SUPER TOP UP/Ver. 1.0/100425.



PEP Declaration:

Are you a Politically Exposed Person (PEP)? Yes No

If yes, please mention the position held

Is any of your close relation or family member a PEP? Yes No

If yes, please mention the name and relation and the position held by such close relative/family member.

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to IndusInd General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"Politically Exposed Persons" (PEPs) shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of stateowned corporations and important political party officials".

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I Understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____

Time: _____

Proposer's Signature*

*Signature authentication: A One Time Password (OTP) authentication number has been sent on Your registered mobile number. By feeding in the said OTP number in the system, You hereby unconditionally and absolutely acknowledge and accept the declarations as stated above in its entirety, and the same would create a legally binding agreement between You and the Company.

Note : The Policy copy and all related documents shall be sent to the email ID provided above. If you wish to receive the Policy copy and related documents in physical form to the aforesaid communication address, please drop us an email at services@indusindinsurance.com

VERNACULAR DECLARATION FOR INTERMEDIARY AND PROPOSER

The contents of this Proposal form have been read over and fully explained to me in _____ language. I further confirm and declare that the contents read over and explained to me have been understood by me.

Place: _____

Date: _____

Signature/Thumb Impression of the Proposer

Explained By Intermediary (Name): _____

Place: _____

Date: _____

PROHIBITION OF REBATES-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.

ACKNOWLEDGEMENT FOR PROPOSAL

Please retain this counterfoil for your records(on behalf of IndusInd General Insurance Company Limited)

Date: D D / M M / Y Y Y Y

Proposal No. _____

We acknowledge the receipt of payment of Rs _____ vide cheque / DD no. _____

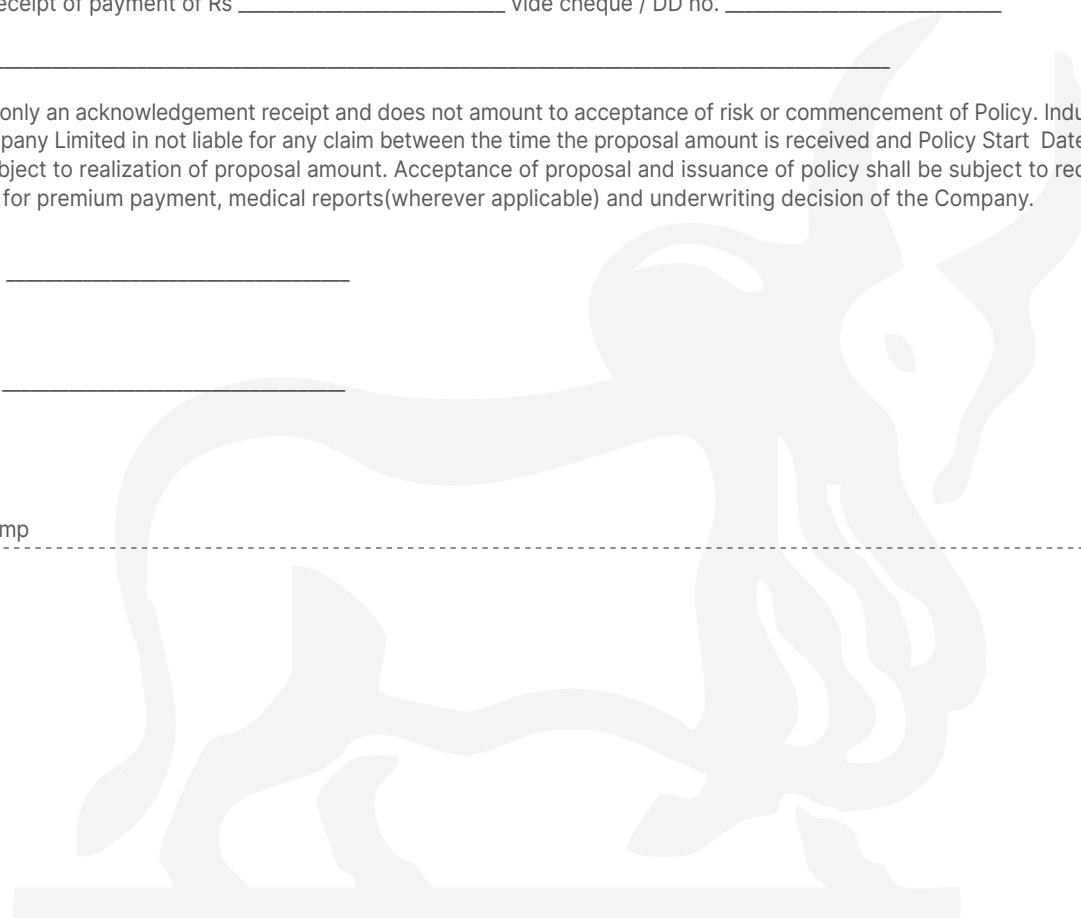
from Mr./Mrs./Ms. _____

Please note that this is only an acknowledgement receipt and does not amount to acceptance of risk or commencement of Policy. IndusInd General Insurance Company Limited in not liable for any claim between the time the proposal amount is received and Policy Start Date. The validity of receipt is subject to realization of proposal amount. Acceptance of proposal and issuance of policy shall be subject to receipt of completed proposal for premium payment, medical reports(wherever applicable) and underwriting decision of the Company.

Name of the Employee _____

Signature of Employee _____

Company Seal and Stamp



indusindinsurance.com



022 4890 3009 (Paid)



74004 22200 (WhatsApp)

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IndusInd Health Super Top Up. UIN: RELHLIP21617V012021. IGI/MCOM/CO/INDUSIND HEALTH SUPER TOP UP/Ver. 1.0/100425.



An Initiative by
BEST BRANDS CONCLAVE

Annexure attached to the Proposal Form

Plan Details (For Reference Only)

The below descriptions are indicative. Please refer the Policy Wordings for complete description, terms and conditions relating to the Covers listed below.

This **Policy** would trigger when the incurred admissible expenses exceed the **Aggregate Deductible** under the **Policy**. This means that all the claims, including those falling within the **Aggregate Deductible**, will be assessed based on the terms and conditions of this **Policy** for working out the admissible expenses.

Expenses related to **Pre Hospitalization** and **Post Hospitalization** in respect of all previous claims would also be taken into consideration. The benefits 1 to 13 and 15 are in-built Policy benefits and shall be available to the Insured Person in accordance with the procedures set out in the Policy.

The benefit 14 is an optional cover under the Policy which shall be available at the end of four continuous and consecutive Hospitalization free Policy Years.

Policy Term Available	Plan A1 year, 2 years, 3 years	Plan B2 years, 3 years
Room Category	Single Private AC Room (upto Deluxe Room)	
Type of Deductible**	Annual Aggregate Deductible	Long Term Aggregate Deductible

Base Covers

Cover	Brief Description	Limits	
1. Hospitalization Expenses	This cover indemnifies the insured for any medical expenses incurred on In-patient Treatment. Pre-Hospitalization and Post-Hospitalization is also covered for the insured for that instance inpatient treatment. This shall also cover Day Care Treatment - i.e. indemnify the insured for the medical expenses incurred under Day care procedure as advised by Medical Practitioner.	Sum Insured is limited to the selected combination of Annual Aggregate Deductible	Sum Insured is limited to the selected combination of Long term Aggregate Deductible.
2. Domiciliary Hospitalization	This cover indemnifies the Insured Person for the medical expenses incurred for treatment under Domiciliary hospitalization	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
3. Maternity Cover	This cover will indemnify the Insured Person for the Medical Expenses related to pregnancy, childbirth, or medically recommended and lawful termination of pregnancy. This cover also includes pre and post natal medical expenses and medical expenses incurred for In-patient treatment of new born baby from day 1 to 90 days	Limited to Rs 2 lakhs subject to Annual Aggregate Deductible	Limited to Rs 2 lakhs subject to Long Term Aggregate Deductible
4. Organ Donor	This cover will indemnify the Insured Person for the Medical Expenses incurred during Hospitalization, in respect of donor for any organ transplant Surgery performed on Insured	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
5. AYUSH Treatment	This cover will indemnify the Insured Person for the Medical Expenses incurred on treatment under Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homeopathy	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible



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An Initiative by
ET
BEST BRANDS CONCLAVE

6. Ambulance Cover	The cover indemnifies the Insured Person for expenses on availing Ambulance services offered by a Hospital or by an Ambulance service provider on Inpatient hospitalization.	Rs 3500 per hospitalization (Within the Sum Insured limits)	Rs 3500 per hospitalization (Within the Sum Insured limits)
7. Emergency Air Ambulance Cover	The cover indemnifies the Insured Person for expenses incurred on availing Air Ambulance services from the place of first occurrence of the Illness/Accident to the nearest Hospital	Maximum upto Rs 2 lakhs for Policies having Sum Insured less than Rs 10 lakhs and Rs 5lakhs for Policies having Sum Insured greater than and equal to Rs 10 lakhs Available once in each Policy Year	Maximum upto Rs 2 lakhs for Policies having Sum Insured less than Rs 10 lakhs and Rs 5lakhs for Policies having Sum Insured greater than and equal to Rs 10 lakhs Available once in each Policy Year
8. Modern Treatments	This cover indemnifies the insured for the medical expenses incurred on treatment of listed Modern Treatments	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
9. Additional Item Cover	This cover indemnifies the Insured Person for Reasonable and customary expenses incurred towards Optional Items listed in Annexure A	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
Personal Accident			
10. Waiver of Deductible for Accidental Claims	This cover waives off the General Exclusion no.5(15)-'Deductible' for Accidental Hospitalization Claims		
Renewal Benefits			
11. Waiver of Premium-On first Diagnosis of Critical Illness	This benefit automatically waives off the renewal Policy premium for one year for the next renewal in case of Diagnosis of any of the listed Critical Illness. For long term policies, the Company shall waive one-year proportionate renewal Policy premium of the next renewal. Aggregate Deductible shall not be applicable to this benefit. This benefit is provided once in the lifetime of the Insured Person		
12. Cumulative Bonus	This renewal benefit will provide 10% of expiring Policy Year Base Sum Insured as Cumulative Bonus at the end of a claim-free Policy Year, subject to a maximum of 50% of Base Sum Insured		
13. Health Check Up	After every 3 consecutive and continuous Policy Years, this benefit shall provide the listed medical check up expenses. The benefit is limited to Rs 3000 for policies with Deductible less than 10 lakhs and upto Rs 5000 for policies with Deductible greater than and equal to 10 lakhs. The benefit shall be available on Cashless basis only.		
14. Deductible-Buy Back (Optional Benefit)*	At the end of four consecutive and continuous Hospitalization free Policy Years, if the Policyholder avails the option to buy back the Deductible amount then no Deductible shall apply on such renewal and the Base Sum Insured under the Policy shall be sum of expiring Policy's Base Sum Insured and expiring Policy's Deductible.		
Renewal Benefits			
15. Worldwide Emergency Cover	This cover indemnifies the Insured Person for the Medical Expenses incurred on Medical Emergency Inpatient, Day Care or outpatient treatment, whilst overseas.	Within the Sum Insured subject to a deduction of USD100 on each and every claim. Available for up to 45 days of international travel on cumulative basis	

The maximum liability of the Company to pay the claims under the Policy is limited to the sum of Sum Insured and Cumulative Bonus. Additionally, the Company shall indemnify the Insured Person as per limits specified above under Benefit-11- Waiver of Premium-On first Diagnosis of Critical Illness and Benefit-13-Health Check Up; and upto the Deductible amount under Benefit-10-Waiver of Deductible for Accidental Claims.

*If Policyholder opts Benefit-14-Deductible Buy back under the Policy then

- i. Benefit - 10: Waiver of Deductible for Accidental Claims shall not be applicable under the Policy.
- ii. Benefit - 13: Health Checkup shall be limited to Rs 5000.