Change Request form



| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | - | -1. | ·, |
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| Policy Number: | | | | | | _ | - | | | | | - | | | _ | | | | | | | | | | | | | | | | |
| Name of Proposer: ease tick the appropriate box and | CII 11- | | 1.1. | · . 0. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Change in Address □ 2. Chan want to opt for a) Protector Rider^ □ Sum Insured under Individual Personal ctor Rider and Hospital Daily Cash Rid isis. Protector Rider and Hospital Daily want to add a □ Pus to n | Accid Accid ers wi Cash |) Ind lent ri II be o Ride | ividu der v offere ers wi | al Pe vill be d on Il be a | 5 (fiv indiv availa | ve) tir ve) tir idual able c | ccider mes th sum on all | nt Ric he Su insure or no | der*C im Ins ed ba: ne ba | sured sis if t sis. | <mark>c) Ho</mark> of Op | o <mark>spita</mark> ptima | <mark>I Dai</mark> Resto | <mark>ly Cas</mark> l ore (Ba | i <mark>Ride</mark> i se Plar | • <mark>^ wit</mark> l) uptc | n <mark>Sum</mark> a ma | ı <mark>Insu</mark> ximur | r <mark>ed</mark> : n of F | ₹ 10 Rs. 1 | <mark>00 pe</mark> Crore | e <mark>r da</mark> and | <mark>y</mark> □ this r | tider \ | 2 <mark>000</mark> vill be | <mark>per</mark> e offe | <mark>day</mark> red c | nly to | the F | Propos | ser. ^ |
| New Address (Address proof to | | | | | an | | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| Name : (Mr./ Ms./ Mrs.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address : | 1 | | | | | - | - | | - | | | | | | | - | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | City/ | ōwn : | | | | | | | | | _ | | | | | | | |
| District : | | | | | | | | | | | | | | State | : | | | | | | | | | | | | | | | | |
| Pin Code : | | | | | | | 1 | | | | | | | Mobil | e: | | | | | | | | | | | | | | | | |
| Telephone : | | | | | | | | | | | | | | E - M | ail : | | | | | | | | | | | | | | | | |
| A. I want to opt for 2-year plan Change in Sum Insured | | 2B. I | wa | nt to | opt | for | 1-yea | ar pla | an 🗆 |] | | | | | | | | | | | | | | | | | | | | | |
| Name of Insured: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| xisting Sum Insured: . Member Deletion/ Addition | | | | | | | | | | | | D | esire | ed Sum | Insur | ed: _ | | | | | | | | | | | | | | | |
| Name of Insured: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Birth | D | D | Μ | M | Y | Y | Y | Y | Ge | nder | | | Mal | le 🗆 | Fema | ale 🗆 | | | | | | | | | | | | | | | |
| Relationship with proposer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| or addition of any individual, fre . Change in Product Name of Insured: | esh pi | ropo | sal | form | sho | buld | be fi | lled. | | | | | | | | | | | | | | | | | | | | | | | |
| Existing Product: | | | | | | | | | | | | | | Desir | ed Pro | duct | | | | | | | | | | | | | | | |
| Desired Sum Insured/ Deductible (in case of Optima Plus product): | | | | | | | | | | | | | | Desir | Desired Plan Variant | | | | | | | | | | | | | | | | |
| Individual/ Floater | | | | | | | | | | | | | | Heigh | t/ We | ght* | | | | | | | | | | | | | | | |
| To be filled only incase Insured shifted Jote: Please enclose an addition Jealth Status Declaration : Post of Ilness/ injury or accident/ medic: f answer is yes, please provide all the re Please note: Any Non Disclosure or Inco f Sum Insured Change is desired for mod Applicable for Easy Health, Optima Res 5. Others, please furnish details: | al she comm al com elevant elevant mplete re tha tore, (| eet f nenc ndition t docu e/ inco n one | or c ceme on c umer orrec e mer | hang ent o ther ts/ in t/ par nber, | f yo f yo tha forma tially pleas | n sur ur ir n co ation corre se us | incluc ect info se add | ance on co ding b ormat ditiona | polie old o out no tion m al she | cy wi r fev t limite nay lea et to g | i th u er? ed to ad to give i | Docto repue | id yo Yes [ors pr diation nation | DU SUff No rescripti n of cla | er fro on, Me m or ca | m or dical ⁻ ancell | are c Test R ation c | urre eports of poli | ntly s etc. | | - | | | | | | ped | any | dise | ease/ | |
| ve accept and agree that: I/ We may have to undergo free or (iii) Addition of insured memb I/ We shall comply with any oth communication received from H I/ We authorize HDFC ERGO C of invitations" | oer/ cl er ade IDFC | hang ditior ERC | je in nal re GO (| prod equir Gene | luct. eme ral Ir | nts i nsura | ncluc ance | ling ı Corr | paym npany | ient c y Ltd. | of ad | Iditio | nal pi | remiur | n towa | rds r | sk loa | ading | , if a | ny, v | vithin | 7 d | ays f | rom | the c | date | of si | uch v | vritter | n | |
| stipulations" | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I hereby declare and warrant th which is relevant in the context Signature of Proposer/ Policy Holde | has b | - | | | | ı beh | nalf of | f all t | he in | sure | d tha | at all | the ir | nforma | | rovide | ed ab | ove a | are ti | ue a | ind co | omp | lete i | n all | resp | ect : | and | no of | her i | nform | natio |

The contents of this form and its particulars have been explained by me in vernacular to the Executant.

| Signature of the Proposer: | | Signature of the Witness: | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Name of Witness: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contact Number: | | | | | | | | | | | | | | | | | | | | | | | | | |
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