Edelweiss | GENERAL INSURANCE

Newborn Care Add-on
Endorsement Request Form

Fields marked with (*) are mandatory.

Proposer's Name*:			
Proposal/Policy Number*:			
Insured Name:			
Address:			
City:	State:	Pin code:	Country:

Change Request in: - At Renewal_____, At Policy_____, At Portability_____.	
Change of Address:	Correction/Change in details of Insured
Member Addition:	Member Deletion:-
Rider Addition:	Rider Deletion:-
Change in proposer:	Others:-
Addition of Health Baby Cover from Day One Add-on	Addition/Deletion:-

Please select any of the below options

☐ Option 1: Upto Maternity Limit
For Gold and Platinum variant

☐ Option 2: Upto Complete Sum insured
For all variants (silver, Gold, platinum)

Any other changes (Existing and Desired changes):-

Name of Insured Individual:	Relation with Proposer	Gender	Date of Birth	Old Sum Insured	New Sum Insured	Height (Feet)	Weight (Kgs)	PED	Claim details

Medical Questions:-

1. Does any Insured or person to be insured has any pre-existing condition illness? ☐ Yes ☐ No
(Provide details). _____
2. Does any Insured or person to be insured is suffering from Diabetes/Hypertension/Epilepsy /Heart Diseases? ☐ Yes ☐ No
(Provide details) _____
3. Does any Insured or person to be insured is suffering from or diagnosed/in the past suffered/treated/taken medication for any health conditions: If yes, please provide details? _____
4. Please provide the details of any existing insurance with current or other insurer

_____

5. *Whether Insured / Spouse is pregnant? If yes, please provide expected delivery date of baby.

* If expected delivery date of baby falls less than or equal to 9 months from first inception of this Add-on then please attach copies of antenatal check-up reports /first consultation paper /USG/Any screening test done.

6. *If self or spouse is not insured then please provide health status details (If receiving any treatment/medication, or has in the past received treatment or undergone surgeries for any medical condition/disability?)

(*Mandatory question if Newborn Care Add-on opted)

Note- Kindly submit:- Health Declaration along with this form.

Declaration:

I hereby declare that the information provided above is true to the best of my knowledge. I hereby declare that there is no change in health status of any existing Insured of the policy.

Date:

Place:

(Signature of the Proposer)

For Office / Branch Use

Branch Name:	Date of Receipt: