CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai - 600 001.
Toll free: 1800 208 9100 | T: +91 (0) 44 4044 5400 | F: +91 (0) 44 4044 5550
E: customercare@cholams.murugappa.com | website: www.cholainsurance.com
IRDA Regn. No.123 | PAN: AABCC6633K | CIN: U66030TN2001PLC047977

REACH US THROUGH WHATSAPP 7305234433

CHANGE REQUEST FORM

Renewal Policy Number: _____

TICK THE APPROPRIATE CHANGES REQUIRED ON THE BELOW OPTION PROVIDED ✓

Increase in SA		Decrease in SA	
Addition of Member		Deletion of member	

IN CASE OF MEMBER ADDITION

NOTE- Details required to be filled for member to be added

S.No.	Name of persons to be insured	Gender (M/F)	Relationship with proposer	Date of birth	Sum Insured	Height in Cms	Weight in Kgs	Marital Status	Occupation

Do any of the persons proposed for insurance have any physical or mental illness / deformities / impairments / undergone any surgeries?	Yes ☐ No ☐
Do any of the persons proposed for insurance suffered from any of the following ailments / diseases? List of diseases: High blood pressure, Chest pain or any other heart disease, Diabetes / Sugar, disorder of the brain / nervous system, Tuberculosis, Asthma, Stomach or duodenal ulcer of any kind, stoke, epilepsy, disorder of gall bladder, liver, stomach or intestines, Varicose veins, varicose ulcers, hernia of any kind, kidney/ bladder/ prostrate disorder, abnormal menstrual period / DUB / Fibroid / Cysts, Arthritis rheumatism or any pain / disorder of the joints, Cancer / tumour / ulcer of any kind, growth of cyst of any kind. Any other illness or disease.	Yes ☐ No ☐

If you answered 'Yes' to any of the above questions, give the details in the table below

S.No.	Name of the persons to be Insured	Illness	Date of treatment	Name / Address of Doctor	Period of treatment	Name / Address of Hospital	Present Status
1							
2							
3							
4							
5							

DETAILS OF PREVIOUS / EXISTING HEALTH INSURANCE POLICY

Do any of the proposed members have any existing Health Insurance Cover? If Yes, provide following details

Name of the persons to be Insured	Insurance Company	Details of Coverage Source	Expiring Policy No.	Date of Commencement of cover*	Policy Expiry Date*	Sum Insured ₹	Claim details	Claim free Bonus (if applicable)* in ₹

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Details of coverage source: IH – Individual Health; FH – Family Floater Health; OH – Other Health Policy
Date of commencement of cover for first time, please enter start date of your existing / previous health Insurance Policy
* Please attach previous policy copies and renewal notices as proof for the initial commencement date

IN CASE OF SUM INSURED ENHANCEMENT

NOTE- Details required to be filled for all existing insured members

S.No.	Name of persons to be insured	Gender (M/F)	Relationship with proposer	Date of birth	Sum Insured	Height in Cms	Weight in Kgs	Marital Status	Occupation

HEALTH STATUS DECLARATION

Post commencement of your insurance policy with us, did you suffer from or are currently suffering from or have developed or investigated for or advised or taken medical opinion or advised surgery for any disease/ illness/ injury or accident/ medical / surgical condition other than common cold or viral fever? Yes ☐ No ☐

If you answered 'Yes' to any of the above questions, give the details in the table below-

S.No.	Name of the persons to be Insured	Illness	Date of treatment	Name / Address of Doctor	Period of treatment	Name / Address of Hospital	Present Status
1							
2							
3							
4							
5							

DETAILS OF PREVIOUS / EXISTING HEALTH INSURANCE POLICY

Do any of the proposed members have any existing Health Insurance Cover? If Yes, provide following details

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Name of the persons to be Insured	Insurance Company	Details of Coverage Source	Expiring Policy No.	Date of Commencement of cover*	Policy Expiry Date*	Sum Insured ₹	Claim details	Claim free Bonus (if applicable)* in ₹

Details of coverage source: IH – Individual Health; FH – Family Floater Health; OH – Other Health Policy
Date of commencement of cover for first time, please enter start date of your existing / previous health Insurance Policy
* Please attach previous policy copies and renewal notices as proof for the initial commencement date

DETAILS TO BE FURNISHED FOR DECREASE IN SA

Name of Insured Person	Gender	Relationship with proposer	Date of birth	Revised Sum Insured

DETAILS TO BE FURNISHED FOR DELETION OF MEMBER

Name of Insured Person	Gender	Relationship with proposer	Date of birth

RENEWAL NOTICE SHOULD BE SUBMITTED ALONG WITH THIS FORM

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 am authorized to propose on behalf of these other persons.

Signature / Thumb Impression of Proposer Name of the Proposer	Date: DD/MM/YYYY	Place: