

CHANGE REQUEST FORM

Guidelines of filling this form

- 1) Please fill the form in block letters.
- 2) Put a tick mark wherever applicable.
- 3) Any alteration in form need to be countersigned by the Policyholder.
- 4) All the details marked * are mandatory.
- 5) Note: Any Change requested for Name/Date of Birth/Address/Contact Details/health condition will be incorporated for all the policies with Us.

Policy Details

Date of Request :

D	D	M	M	Y	Y	Y	Y
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Name of the : _____

Product : _____

Policy Number* : _____

Policyholder Name* : _____

Change in Name

Policyholder Insured

From (Name as per the current policy)	To (To be changed to)
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

Document Submitted* : Pan Card Gazetted Notification Driving License

Election Card Aadhar Card

Others (Please Specify) : _____

Note :

- a) Women who wish to change their name/surname post marriage, are requested to forward a copy of the marriage certificate.
- b) For all other requests with significant name change, a copy of gazetted notification is required.
- c) Certified true copy of the supporting document should also be enclosed.

DHFL General Insurance Limited

(A Wholly Owned Subsidiary Of WGC)

Registered & Corporate Office: 402, 403 & 404, A&B Wing, 4th Floor, Fulcrum, Sahar Road, Next to Hyatt Regency, Andheri (E), Mumbai - 400 099.

Phone: 022 - 4001 8100/8200

IRDAI Reg No.: 155

PRODUCT UIN: DHFHLIP18131V011718

CIN: U66000MH2016PLC283275

GSTIN: 27AAFCD7985H1Z4

COCOProtect – Change Request Form

Web: www.dhflinsurance.com

Email: mycare@dhflinsurance.com

Change in Date of Birth																																																																		
<input type="checkbox"/> Policyholder <input type="checkbox"/> Insured																																																																		
Name of Insured	From (DOB as per policy)	To (To be changed to)																																																																
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Document Submitted* : <input type="checkbox"/> Pan Card <input type="checkbox"/> Passport <input type="checkbox"/> Driving License <input type="checkbox"/> Others (Please Specify) _____																																																																		

Change in Occupation		
Name of Insured	Occupation as declared in policy*	Current Occupation*
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

Change in Address	
New Address	: _____
City*	: _____ State* : _____
Pin Code*	: _____

Change in Contact Details	
Mobile Number	: _____ Landline Number : _____
Email ID	: _____

Change of Nominee (Nominee should be more than or equal to 18 years of age)	
Name of Nominee	: _____
Relationship with Policyholder	: _____

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Deletion of Insured Person				
Name of Insured*	Gender*	DOB (DD/MM/YYYY)*	Relationship	Reason for deletion
1) _____				
2) _____				
3) _____				
4) _____				

Inclusion of Health Condition		
Name of Insured	Name of Illness/Disease	Date of first Diagnosis
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

Any Other Change Request	
<input type="checkbox"/> Policyholder	<input type="checkbox"/> Insured
Name* : _____	
(In case there is any alteration to the information you furnished at the time of proposing of cover, please provide the same below.)	
Change From : _____	
Change To : _____	

Declaration							
I hereby confirm having read and understood all the policy terms and conditions including those applicable to this request. I understand and accept that my request shall be processed in accordance with the terms and conditions of the Policy.							
_____	Date : <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> </tr> </table>	D	D	M	M	Y	Y
D	D	M	M	Y	Y		
Signature/Thumb impression of Policyholder	Place : _____						

Disclaimer
Your Policy has been issued based on the declarations on the proposal form filled at the time of taking the first policy from Us. The rates, terms & conditions of the policy have been determined based on this information. Wherever there has been any material change to this information, We shall be entitled to modify or vary the terms of insurance and/or premium, if necessary, accordingly. Any change in terms or premium will be communicated to You in writing and the Policy will be renewed after your specific consent to such changes.

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Acknowledgement Slip											
Policy Number	: _____										
Name of Policyholder	: _____										
Request for	: _____										
Request Received by	: _____ Branch : _____										
Date and time of receipt	: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;">D</td><td style="width: 20px; height: 20px;">D</td></tr> </table> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;">M</td><td style="width: 20px; height: 20px;">M</td></tr> </table> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;">Y</td><td style="width: 20px; height: 20px;">Y</td></tr> </table> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;">H</td><td style="width: 20px; height: 20px;">H</td></tr> </table> : <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;">M</td><td style="width: 20px; height: 20px;">M</td></tr> </table>	D	D	M	M	Y	Y	H	H	M	M
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Signature & Stamp of DHFL General Insurance											

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