

1. I/We 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/We am/are authorized to propose on behalf of these other persons.

2. 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 insurance company and that the policy will come into force only after full receipt of the premium chargeable.

3. I/We further declare that I/we 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.

4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

5. I/We authorize the company to share information pertaining to my personal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority.

PLACE:

DATE:

Signature of the proposer

Section 41 OF INSURANCE ACT 1938

➤ PROHIBITION OF REBATES <

- (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 a part of commission payable or any rebates of the premium- shown on the policy nor shall any person taking out or renewing continuing a policy except any rebate as may be allowed in accordance with the published prospectus or tables of the insurer.
- (2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to five hundred rupees.

- (a) Insurer, Policy No. and
Period of cover :
- (b) Claim Amt. Recd. / Receivable :
Period : From: TO:

11. Any Proposal for this Insurance or any other similar insurance refused Or cancelled or higher premium charged. If so give details:

12. MEDICAL HISTORY TO BE COMPLETED BY THE PROPOSER / INSURED PERSON

PLEASE ANSWER THE FOLLOWING QUESTIONS IN YES OR NO. (A DASH IS NOT SUFFICIENT) AND GIVE FULL DETAILS IF ANSWER IS YES.

12.1 Are you in good health and free from Physical and mental diseases or infirmity Or medical complaints?

12.2 If not in good health give full details

13. Have you ever suffered from any of the diseases / illness? If yes, give details :

- (a) any nervous, mental or psychiatric disease
- (b) slipped disc or other spinal disorder (fainting episode, blackout, fit) paralysis of any kind
- (c) high blood pressure, heart diseases, including ischaemic heart disease, other circulatory disorder etc., (rheumatic fever)
- (d) Fistula, Piles, hernia, varicose veins
- (e) Any disease of the bones or joints Including rheumatic disease
- (f) diseases of uterus, ovaries or breast or any specific gynaecological disorders
- (g) any respiratory or allergic disease
- (h) any disorder of the stomach, ulcer, bowel or gall bladder, kidney stones etc.,
- (i) any cancer, malignant growth, boil, cyst or wound etc., which does not heal or improve despite treatment
- (j) any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations
- (k) any complaint or tendency that may necessitate such consultation or treatment in the future
- (l) any dimness of vision / cataract
- (m) any disease of ears or difficulty or interference with hearing
- (n) diabetes or any urinary diseases
- (o) any other illness or disease or accident or operation sustained by you.

14. (a) Have you ever suffered from dental problems ? Yes / No
- (b) If yes specify same
- (c) When were you treated last for same

15. Give particulars in table below of any other illness or disease or accident or operation sustained by you in the past

S.N.	Nature of illness / disease injury and treatment received	First diagnosed	Name of attending medical practitioner, surgeon with his address and Telephone Number	Treatment taken	Whether fully cured
1.					
2.					
3.					
4.					

16. Are there any additional facts affecting the proposed insurance which should be disclosed to Insurers ? -----

17. Please give details of any knowledge of any positive Existence or presence of any ailment, sickness

Or injury which may require medical attention.

- 1.
- 2.
- 3.
- 4.

18. Please specify sum Insured opted: Rs.

I hereby declare and warrant that the above statements are true and complete. I consent and authorise the Insurers to seek medical information from any Hospital / Medical Practitioner who has at any time attended or may attend concerning any disease or illness which affects my physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be effected. If after the insurance is effected, it is found that the statements, answers or particulars stated in the Proposal form and its questionnaires are incorrect or untrue in any respect, the Insurance Company shall incur no liability under this insurance.

I have read the Prospectus and am willing to accept the coverage subject to the terms, conditions and exceptions stated therein and expressed in the Policy.

Signature ----- Date ----- / ----- / -----

Place: -----

NAME OF THE PROPOSER / INSURED PERSON -----
(IN BLOCK LETTERS)

N.B: This should necessarily be signed by insured person. In case of minor, guardian or proposer may sign.

FOR OFFICE USE

Basic Premium for Scheme ... Rs.
Premium for Additional covers opted Rs.

Staff Discount ... Rs.

TO BE COMPLETED BY PROPOSER IN CASE OF ADVERSE HISOTRY
IN THE PROPOSAL FORM IN RESPECT OF APPLICABLE ILLNESS:

DIABETES QUESTIONNAIRE:

1.	Date of diagnosis of Diabetes	
2.	Did you suffer from coma or procoma ?	
3.	Do you take any anti diabetic drugs ? If so please give names with dose.	
4.	Please give details of Fasting and post prandial Blood Sugar readings, E.C.G. findings and other investigation reports with dates. Please also attach reports	
5.	Do you suffer or have you suffered from any complications of diabetes or any other diseases?	

HYPERTENSION QUESTIONNAIRE

1. What is your Blood Pressure reading, please state with dates?
2. Please state name of antihypentensive drugs with dose
3. Are you a smoker?
4. Is it essential / secondary / Malignant Hypertension?
5. Please state whether you have suffered from any complications or other diseases
6. Please give findings of all investigation reports

**CHEST PAIN OR CORONARY INSUFFICIENCY
OR MYOCARDIAL INFARCTION QUESTIONNAIRE:**

1. Did you ever suffer from chest pain or coronary insufficiency or myocardial infarction ? If so give please give diagnosis and date
2. Please state name and doss of drugs you are taking at present
3. Please state the findings with dates of investigations done like ECG, stress test, coronary angiography's X-ray, pathology reports etc., Please send reports with the prescribed form.
4. Please state the date of hospitalisation and names of hospitals and consults

5. Please state complications and other diseases if suffered
6. Please state whether you can do your regular work and whether you have any limitation of activity?
7. Are you advised any special treatment? If so please give information

Signature of Proposer/Insured person

PLACE :
DATE:

TO BE COMPLETED BY CONSULTING PHYSICIAN / SURGEON
(in case of adverse Medical History)

1. Name of the Insured:
2. HISTORY
 - a) Present complaints and investigation if any
 - b) Any past history of disease, operation, accidents investigations with date, major medical complaints or hospitalisation
 - c) Details of present and past medication with duration
 - d) Is he cured of disease, if any? When, was your treatment, if any, given, stopped?
3. General Examination
4. Systematic Examination
5. Do you consider the risk acceptable

Signature of proposer

Signature of consulting physician

Name of consulting Physician:
Qualifications:
Address:

Place:
Date:

Telephone Number:

TO BE COMPLETED BY OFFICIAL OF INSURANCE COMPANY -----

DO YOU CONSIDER THE RISK ACCEPTABLE?

COMPETENT AUTHORITY