

Declaration of Good Health of the life to be insured (if applicable)

Policy number Proposal number	Name of Life Insured Date of birth	DD / MM / YY	Gender	<input type="checkbox"/>	<input type="checkbox"/>
Contact number	Name of Second Life Insured			Male	Female
Email	Date of Birth Second Life Insured	DD / MM / YY	Gender	<input type="checkbox"/>	<input type="checkbox"/>
				Male	Female

Do you wish to change your current communication address? Yes No
 If yes, please mention the current address below (TO BE FILLED IN CAPITAL LETTER ONLY).

SECTION A
*** APPLICABLE FOR NNU/TEMPLATED PRODUCTS**

(**Product Code example:** TSB, ELP, SPT, MBT, IBT, AWT, WPT, YST, ANT, ANG, ELI, LBG, LBI, CBG, EPI, PPG, TAS, TSA, TPG, SVG, NSG, SPI, SPG, NPI, NPG, NLG, NLI, REG, LPG, RBG, RSG, LFG, RPG, RTG, OPG, WTG, OPI, RBI, WTI, RPI, REI, JSG, ASG, CBI, EPG, PPI, TPI, APG, SPP, LLD, FLD, LSD, LBD, AEL, ASV, TGS, SCG, APE)

1. Since the date of the Proposal as mentioned above	First Life	
a) Are you in good health?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b) Have you ever had a heart condition, a stroke, hypertension, paralysis, cancer, diabetes, kidney failure, liver failure, mental illness, HIV infection or AIDS?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c) Do you currently have, or are you receiving treatment for any symptoms, medical conditions or disabilities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d) Have you been absent from work due to illness or injury for a continuous period of more than 10 days during the last one year?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e) Have you undergone or been advised to undergo a medical examination/ medical tests or any investigations?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f) Has there been any change in your mode of habits (smoking, alcohol use) occupation or country of residence?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
g) Has a proposal on your life or an application for revival of policy on your life made to this or any other insurer ever been withdrawn or dropped, deferred or declined, accepted with an extra premium or lien or terms other than those proposed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
For Female Lives only:		
i. Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ii. Have you had, or do you have any complications of pregnancy at present or in the past?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
iii. Have you had, or do you have any gynecological problem?" to the female lives questions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If answer to the above questions is 'Yes' except for Q1A, Please provide full details in box below and provide related documents "		

SECTION B
*** APPLICABLE ONLY FOR NUP/UNDERWRITING PRODUCTS**

(**Product Code example:** LSP, LBF, ALL, LSS, AWP, AWN, AYS, LSG, LSI, LLG, LLI, CLG, CSG, TSL, TLS, YAG, LFB, LBP, FLG, RFG, TIB, RLG, WLG, WSG, RYG, WLI, WSI, RYI, CLI, CSI, YAI, LMG, ALB, ALP, ALN, ASP, LSV, LSU, TMB, AIB, ASS, AFL, ALS, ALM, TSP, TDV, AHP)

Since the date of the Proposal as mentioned above	First Life		Second Life	
A. Are you currently receiving any medical treatment or are you awaiting medical or surgical consultation, test or investigation? (You need not disclose matters relating to uncomplicated pregnancy, common colds, influenza, hay-fever or any minor ailment requiring a single consultation)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
B. Have you ever had any medical or surgical treatment, including investigations, tests, scans or X-Ray for any of the following illnesses or medical conditions:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
i. High blood pressure, angina, heart attack, stroke or any other disorder of heart or circulation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ii. Any form of cancer, tumor or growth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
iii. Disorder of skin or lymph glands?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
iv. Diabetes, kidney or liver problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

