

	Yes	No	Yes	No
5. Kidney or Urinary Bladder, Stones, Prostate Disorder or Genitourinary Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Multiple Sclerosis, Epilepsy, Tremor, Numbness, Double Vision or Giddiness, Paralysis, Mental or Nervous Illness (including depression)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Asthma, Bronchitis, Pneumonia, TB or any other respiratory or Lung disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Birth disorders, Anemia, Leukemia, disorder of Lymph Glands or other Blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Disorder of Skin, Back, Muscle, Joints, Arthritis, Gout, Bodily Deformity, Amputation, Bone Fracture or any other disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Were you or your spouse ever diagnosed with Hepatitis B or C, HIV/AIDS or any other sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Any other Illness, Surgery, Injury, Treatment pertaining to condition not listed above? E.g. persistent fever, unexplained weight loss, loss of appetite, pain, swelling etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you undergone or have been advised to undergo any surgery or investigations in the last two years like ECG, Ultrasound(USG), Color Doppler, Chest X-ray, Endoscopy, MRI Scan, CT Angiogram, 2D Echo, TMT, Cytology, Cardiac Markers, PET Scan, etc. excluding normal results of insurance medicals/regular/routine/executive health checkups and other than accidental reasons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* **Politically Exposed Person (PEP)** are individuals who are or have been entrusted with prominent public functions, for example Heads/Ministers of Central/State Government, Senior Politicians, Senior Government/ Judicial/Military Officers, Senior Executive of State Owned Corporations, important party officials and immediate family members of above persons (spouse, children, parents, siblings and in-laws)

DETAILS

DECLARATION

I/We do hereby agree & declare that the above statements and answers shall be the basis of the reinstatement of the lapsed policy and/or rider contract to be issued or revived between me/us and the Company and that I/We have made complete, true and accurate disclosure of all the facts and circumstances as may be relevant, and have not withheld any information that may be relevant to enable the Company to make an informed decision about the acceptability of the risk. I fully understand that the revival of my policy/issuance of the rider shall be subject to company underwriting the risk afresh, life to be Insured undergoing medical tests (whenever required), realization of applicable charges for revival and confirming the revival/issuance of rider details in writing to the policyholder. Further I fully understand that the company reserves the right to impose any extra premium as results of underwriting. I fully understand that the revival of my policy/issuance of the rider shall be subject to the sole discretion of the Company. I fully understand that the revival of a Lapsed Policy/issuance of rider is also subject to payment of revival fee/rider premium in favour of the Company. I am also aware that at the time of revival, the cost of medical examination and special tests, if any, will be borne by the Policyholder. Units, if any, shall be allocated at the reinstatement date. I/We undertake to notify the Company, forthwith in writing, of any change in any of the statements made in the declaration of good health form subsequent to the signing of this declaration of good health and prior to acceptance of risk and revival of the policy/issuance of the rider by the Company.

Signature/Thumb Impression
of Life Insured

Signature/Thumb Impression
of Proposer or Joint Life Insured

Date

D	D	M	M	Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Place _____

In case of Policyholder is illiterate/Thumb impression/Understands language other than English: I hereby declare that I have explained the contents of this form to the Policyholder/Life Insured in _____ Language and that the Policyholder/Life Insured has affixed the thumb impression(s) above after fully understanding the contents.

Declarant's Name _____ Declarant's Signature _____

Declarant's Address & Contact Number _____

FOR BRANCH USE ONLY

Service Request ID

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Branch Name _____

Processed by (Name & Signature)

Branch Stamp & Date



Aviva Life Insurance Company India Limited
401-A, 4th Floor, Block A, DLF Cyber Park,
Sector-20, NH-8, Gurugram, Haryana-122 016
www.avivaindia.com



Customer Service Helpline Number
1800-103-77-66 (Toll Free)
0124-270-9046



Email
customerservices@avivaindia.com

Proposal Number

Customer Name

COVID-19 (Coronavirus) Exposure Questionnaire

	Yes	No								
1. Are you, or your family have you been in close contact with anyone who has been quarantined or who has been diagnosed with novel coronavirus (SARS-CoV-2/COVID-19) ? If yes, please provide details. <hr/> <hr/>	<input type="checkbox"/>	<input type="checkbox"/>								
2. Are you, or your family have you ever been serving a notice of quarantine in any form imposed by local health authorities or government or airport authority for possible exposure to novel coronavirus (SARS- CoV2/COVID-19)? If yes, please provide more details like location, dates, quarantine period. <hr/> <hr/>	<input type="checkbox"/>	<input type="checkbox"/>								
3. Have you been advised to be tested to rule in, or rule out, a diagnosis of novel coronavirus (SARSCoV-2/COVID-19)? Or, are you awaiting the result of a test which has already been submitted for the novel coronavirus (SARS-CoV-2/COVID-19)? <hr/> <hr/>	<input type="checkbox"/>	<input type="checkbox"/>								
4. Have you ever tested positive for the novel coronavirus (SARS-CoV-2/COVID-19)? If yes, provide the date of positive diagnosis. And also details of subsequent tests. <hr/> <hr/>	<input type="checkbox"/>	<input type="checkbox"/>								
5. Have you experienced any of the following symptoms within the last 14 days? <ul style="list-style-type: none"> • Any fever • Cough • Shortness of breath • Malaise (flu-like tiredness) • Rhinorrhea (mucus discharge from the nose) • Sore throat • Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhea If yes, to any of these, please indicate which and provide full information.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>								
6. Are you a Healthcare professionals (Include for instance General Practitioners, Doctors, Hospital Doctors, Surgeons, Therapists, Nurses, Pathologist, paramedics, Pharmacist, Ward helpers, Individuals working in Hospitals/ Clinics having novel coronavirus (SARS-CoV-2/COVID-19) Ward ? if yes , please provide details whether working in Hospital with Covid-19 ward or treating or in contact with Covid019 infected individuals.	<input type="checkbox"/>	<input type="checkbox"/>								
7. If Q6 is Yes , please provide more details in terms of daily duties including details whether enrolled as Corona virus warrior or working in Hospital/ clinic with novel coronavirus (SARS-CoV-2/COVID-19) ward/unit or treating/ in contact with SARS-CoV-2/COVID-19 infected individuals. <hr/> <hr/>										
8. Travel Declaration a. Are you currently residing outside of India? If Yes, Please provide your details: <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr style="background-color: #0056b3; color: white;"> <th style="width: 25%;">COUNTRY</th> <th style="width: 25%;">CITY</th> <th style="width: 25%;">DATE OF TRAVEL</th> <th style="width: 25%;">INTENDED DURATION</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	COUNTRY	CITY	DATE OF TRAVEL	INTENDED DURATION					<input type="checkbox"/>	<input type="checkbox"/>
COUNTRY	CITY	DATE OF TRAVEL	INTENDED DURATION							
b. Have you travelled abroad in the past 14 days? If Yes, Please provide your travel details over the past 14 days: <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr style="background-color: #0056b3; color: white;"> <th style="width: 25%;">COUNTRY</th> <th style="width: 25%;">CITY</th> <th style="width: 25%;">DATE ARRIVED</th> <th style="width: 25%;">DATE DEPARTED</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	COUNTRY	CITY	DATE ARRIVED	DATE DEPARTED					<input type="checkbox"/>	<input type="checkbox"/>
COUNTRY	CITY	DATE ARRIVED	DATE DEPARTED							
b. Do you intend to travel abroad in next 3 months: If Yes, Please provide details of your intended future travel within next 3 months: <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr style="background-color: #0056b3; color: white;"> <th style="width: 25%;">COUNTRY</th> <th style="width: 25%;">CITY</th> <th style="width: 25%;">DATE OF TRAVEL</th> <th style="width: 25%;">INTENDED DURATION</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	COUNTRY	CITY	DATE OF TRAVEL	INTENDED DURATION					<input type="checkbox"/>	<input type="checkbox"/>
COUNTRY	CITY	DATE OF TRAVEL	INTENDED DURATION							



Aviva Life Insurance Company India Limited
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 Sector-20, NH-8, Gurugram, Haryana-122 016
www.avivaindia.com



Customer Service Helpline Number
 1800-103-77-66 (Toll Free)
 0124-270-9046



Email
customerservices@avivaindia.com

	Yes	No
9. COVID19 Vaccination details	<input type="checkbox"/>	<input type="checkbox"/>
Have you been vaccinated for COVID19?		
If Yes		
• Date of administration of the first dose		

• Date of administration of the second dose		

• Name of vaccine		

• Have you experienced any adverse reaction post vaccination ?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please share details including treatment taken for the same and date of complete recovery		

Clients to share Copy of vaccination certificate (or copy of any official documentation confirming complete vaccination & issued by the relevant health authority)
Please note self-declarations are not acceptable.

Declaration

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).
Signed at _____ on this day _____ of _____, _____ .

Applicant Signature

Declaration by the Person filling the form

(IN CASE SIGNATURE IS IN VERNACULAR LANGUAGE, THUMB IMPRESSION AND/OR IN CASE THE QUESTIONNAIRE HAS NOT BEEN FILLED IN BY THE PROPOSER)
I hereby declare that I have fully explained the contents of the questionnaire to the Life the Insured/Proposer and that he/she has fully understood the same and I have truthfully recorded the answers given by the Life to be Insured/Proposer. Enclose identity proof of the declarant.

Declarant's Name and Address

Pincode _____

Signature of Declarant

Signature of Advisor/SP

में यह घोषित करता हूँ की मैंने इस प्रस्ताव फॉर्म को पूरी तरह समझ लिया है, और इस प्रस्ताव फॉर्म में मैंने सभी सवालों के जवाब अपनी जानकारी के हिसाब से पूर्णतः सही दिए हैं।

Handwritten Vernacular Declaration

I hereby declare that the contents of this application of insurance have been fully explained to me & I have fully understood the significance of the proposed contract. This proposal form shall be a part of the life insurance policy contract, in case of its acceptance by the company.

Witness's Name and Address

Pincode _____

Signature of Witness

Signature of Life to be Insured /Proposer