Declaration of Good Health for Reinstatement

Policy No. | | | | | | | | | | | | Contact No. | | | | | | | | | | Email ID _____

Name of Life Insured _____ Date of Birth of Life Insured D D M M Y Y Y Y

Name of Second Life Insured (If applicable) _____ Date of Birth of Second Life Insured D D M M Y Y Y Y

SECTION A: MANDATORY SECTION FOR ALL **(If answer to any question is 'Yes', please provide information in the Details section)**	First Life		Second Life/ Life Insured	
	Yes	No	Yes	No
1. Any change in occupation or do you plan to travel for a long duration or reside abroad (other than on a holiday for less than 3-4 weeks)? If yes, please give details for Occupation, Country Name, Purpose of visit and Duration of Stay.	○	○	○	○
2. Has any of your insurance proposal or reinstatement of policy for Life, Health or Critical Illness ever been withdrawn, deferred, declined, rejected, terminated, offered with an extra premium, lien or modified by Aviva or any other Company? If yes, please give details for Reason, Company Name and Year.	○	○	○	○
3. Are you, proposer or nominee stated in the policy Politically Exposed* whether currently or in the past?	○	○	○	○
4. Has there ever been any criminal charges or proceedings pending against you currently or in the past and/or were you ever convicted in any criminal proceedings and/or are on bail/probation/suspended/sentenced?	○	○	○	○
5. Have you ever been off work or observed restriction of your normal daily activities due to any illness or injury for a continuous period of more than 5 days?	○	○	○	○
6. Have you ever been or since the time of proposal suffered, diagnosed with or investigated or awaiting investigations, surgery or received treatment, surgery or consulted any doctor for any disability or medical condition other than minor impairment such as common cold?	○	○	○	○
7. Have you in the past (2 years) or do you consume tobacco/nicotine products like Cigarettes, flavored Pan Masala, Cigars, Bidis, Narcotics, etc.? If yes, please state the duration and quantity consumed per day	○	○	○	○
8. **For Female lives only:** (a) Are you pregnant? (b) If yes, number of weeks pregnant	○	○	○	○
(c) Any complications of pregnancy at present or in the past or have you ever suffered/are suffering from any disorder of Uterus, Cervix, Ovaries, Breast, etc?	○	○	○	○
9. Height and Weight details: Height (in cms) / Weight (in kgs)				
(a) Have you experienced any changes in weight of more than 5 kgs in the past 1 year?	○	○	○	○
(b) If yes, how many kgs? ☐ Loss ☐ Gain _____ Kgs Reason for the same _____ (For First Life)				
☐ Loss ☐ Gain _____ Kgs Reason for the same _____ (For Second Life /Life Insured)				

SECTION B: TO BE FILLED FOR REINSTATEMENT OF HEALTH/CRITICAL ILLNESS PRODUCTS & RIDER/S Have you ever been investigated, treated or diagnosed with any of the following conditions. (If answer to any question is 'Yes', please provide information in the details section).	First Life		Second Life/ Life Insured	
	Yes	No	Yes	No
1. High Blood Pressure, heaviness, pain or discomfort in Chest, Angina, Heart Attack, Stroke or any other disorder of heart, Blood circulation or Heart Surgery?	○	○	○	○
2. Any form of Cancer, Tumor, Lump or growth (Benign or Malignant)?	○	○	○	○
3. Diabetes, High Blood Sugar or Thyroid problem?	○	○	○	○
4. Liver disorders like Cirrhosis, Hepatitis, Jaundice; Disorders of the Stomach, Gall Bladder or Intestines, Ulcer, Gall Stones, Colitis, Chronic Diarrhoea, Indigestion?	○	○	○	○

	Yes	No	Yes	No
5. Kidney or Urinary Bladder, Stones, Prostate Disorder or Genitourinary Disorder	○	○	○	○
6. Multiple Sclerosis, Epilepsy, Tremor, Numbness, Double Vision or Giddiness, Paralysis, Mental or Nervous Illness (including depression)	○	○	○	○
7. Asthma, Bronchitis, Pneumonia, TB or any other respiratory or Lung disorder?	○	○	○	○
8. Birth disorders, Anemia, Leukemia, disorder of Lymph Glands or other Blood disorder?	○	○	○	○
9. Disorder of Skin, Back, Muscle, Joints, Arthritis, Gout, Bodily Deformity, Amputation, Bone Fracture or any other disorder?	○	○	○	○
10. Were you or your spouse ever diagnosed with Hepatitis B or C, HIV/AIDS or any other sexually transmitted disease?	○	○	○	○
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.	○	○	○	○
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?	○	○	○	○

* **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)
		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 _ _ _ _ _ _ _ _ _ _ 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.	○	○
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.	○	○
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)?	○	○
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.	○	○
5. Have you experienced any of the following symptoms within the last 14 days? • 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.	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○ ○
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.	○	○
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.		
8. Travel Declaration a. Are you currently residing outside of India? If Yes, Please provide your details:	○	○
b. Have you travelled abroad in the past 14 days? If Yes, Please provide your travel details over the past 14 days:	○	○
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:	○	○

COUNTRY	CITY	DATE OF TRAVEL	INTENDED DURATION

COUNTRY	CITY	DATE ARRIVED	DATE DEPARTED

COUNTRY	CITY	DATE OF TRAVEL	INTENDED DURATION

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0124-270-9046

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customerservices@avivaindia.com

	Yes	No
9. COVID19 Vaccination details 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 ? 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

मैं 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 है।

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

Aviva Life Insurance Company India Limited
401-A, 4th Floor, Block A, DLF Cyber Park,
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0124-270-9046

Email
customerservices@avivaindia.com

Mention correct Policy Number starting with first cell, e.g.-12345678.

Correct email ID and contact number need to be mentioned.

Name needs to be mentioned as per policy.

AVIVA
Life Insurance

Declaration of Good Health for Reinstatement

Policy No. | Contact No. | Email ID

Name of Life Insured | Date of Birth of Life Insured (D D M M Y Y Y Y)

Name of Second Life Insured (If applicable) | Date of Birth of Second Life Insured (D D M M Y Y Y Y)

Please fill in case of second life insured only*.

SECTION A: MANDATORY SECTION FOR ALL (If answer to any question is 'Yes', please provide information in the Details section)	First Life		Second Life/ Life Insured	
	Yes	No	Yes	No
1. Any change in occupation or do you plan to travel for a long duration or reside abroad (other than on a holiday for less than 3-4 weeks)? If yes, please give details for Occupation, Country Name, Purpose of visit and Duration of Stay.	☐	☐	☐	☐
2. Has any of your insurance proposal or reinstatement of policy for Life, Health or Critical Illness ever been withdrawn, deferred, declined, rejected, terminated, offered with an extra premium, lien or modified by Aviva or any other Company? If yes, please give details for Reason, Company Name and Year.	☐	☐	☐	☐
3. Are you, proposer or nominee stated in the policy Politically Exposed* whether currently or in the past?	☐	☐	☐	☐
4. Has there ever been any criminal charges or proceedings pending against you currently or in the past and/or were you ever convicted in any criminal proceedings and/or are on bail/probation/suspended/sentenced?	☐	☐	☐	☐
5. Have you ever been off work or observed restriction of your normal daily activities due to any illness or injury for a continuous period of more than 5 days?	☐	☐	☐	☐
6. Have you ever been or since the time of proposal suffered, diagnosed with or investigated or awaiting investigations, surgery or received treatment, surgery or consulted any doctor for any disability or medical condition other than minor impairment such as common cold?	☐	☐	☐	☐
7. Have you in the past (2 years) or do you consume tobacco/nicotine products like Cigarettes, flavored Pan Masala, Cigars, Bidis, Narcotics, etc.? If yes, please state the duration and quantity consumed per day	☐	☐	☐	☐
8. **For Female lives only:** (a) Are you pregnant? (b) If yes, number of weeks pregnant ☐☐☐ (c) Any complications of pregnancy at present or in the past or have you ever suffered/are suffering from any disorder of Uterus, Cervix, Ovaries, Breast, etc?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
9. Height and Weight details: Height (in cms) Weight (in kgs) (a) Have you experienced any changes in weight of more than 5 kgs in the past 1 year? (b) If yes, how many kgs? ☐ Loss ☐ Loss ____ Kgs Reason for the same ____ (For First Life) ☐ Loss ☐ Loss ____ Kgs Reason for the same ____ (For Second Life /Life Insured)	☐☐☐ ☐☐☐ ☐	☐☐☐ ☐☐☐ ☐	☐☐☐ ☐☐☐ ☐	☐☐☐ ☐☐☐ ☐

Mention height in cms only. For e.g., if your height is 5 feet 8 inches, please write 173 cms. Mention weight in kgs.

If you have ticked "YES" against question 9a), please select options for question 9b) also.

Leave it blank if you do not have rider or critical illness product.

SECTION B: TO BE FILLED FOR REINSTATEMENT OF HEALTH/CRITICAL ILLNESS PRODUCTS & RIDER/S Have you ever been investigated, treated or diagnosed with any of the following conditions. (If answer to any question is 'Yes', please provide information in the details section).	First Life		Second Life/ Life Insured	
	Yes	No	Yes	No
1. High Blood Pressure, heaviness, pain or discomfort in Chest, Angina, Heart Attack, Stroke or any other disorder of heart, Blood circulation or Heart Surgery?	☐	☐	☐	☐
2. Any form of Cancer, Tumor, Lump or growth (Benign or Malignant)?	☐	☐	☐	☐
3. Diabetes, High Blood Sugar or Thyroid problem?	☐	☐	☐	☐
4. Liver disorders like Cirrhosis, Hepatitis, Jaundice; Disorders of the Stomach, Gall Bladder or Intestines, Ulcer, Gall Stones, Colitis, Chronic Diarrhoea, Indigestion?	☐	☐	☐	☐

	Yes	No	Yes	No
5. Kidney or Urinary Bladder, Stones, Prostate Disorder or Genitourinary Disorder	☐	☐	☐	☐
6. Multiple Sclerosis, Epilepsy, Tremor, Numbness, Double Vision or Giddiness, Paralysis, Mental or Nervous Illness (including depression)	☐	☐	☐	☐
7. Asthma, Bronchitis, Pneumonia, TB or any other respiratory or Lung disorder?	☐	☐	☐	☐
8. Birth disorders, Anemia, Leukemia, disorder of Lymph Glands or other Blood disorder?	☐	☐	☐	☐
9. Disorder of Skin, Back, Muscle, Joints, Arthritis, Gout, Bodily Deformity, Amputation, Bone Fracture or any other disorder?	☐	☐	☐	☐
10. Were you or your spouse ever diagnosed with Hepatitis B or C, HIV/AIDS or any other sexually transmitted disease?	☐	☐	☐	☐
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.	☐	☐	☐	☐
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?	☐	☐	☐	☐

Please share details if your answer to any question is "Yes" in section A or B.

*** 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

In case of a manually filled form, Policy owner to sign here.

In case of a manually filled form, Joint life insured to sign here.

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

Place

Mention current date and 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.

If signature is in vernacular language (i.e. other than English) or policyholder is illiterate then please fill declarant's details and provide photo ID proof.

Declarant's Name _____ Declarant's Signature _____

Declarant's Address & Contact Number _____

FOR BRANCH USE ONLY

Service Request ID ☐☐☐☐☐☐☐☐☐☐ Branch Name _____

Processed by (Name & Signature)

Branch Stamp & Date

Aviva Life Insurance Company India Limited
401-A, 4th Floor, Block A, DLF Cyber Park,
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Customer Service Helpline Number
1800-103-77-66 (Toll Free)
0124-270-9046

Email
customerservices@avivaindia.com

Mention correct policy/proposal number starting with first cell, e.g.-12345678.

Customer name needs to be mentioned.

Proposal Number

Customer Name

AVIVA
Life Insurance

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.	☐	☐
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.	☐	☐
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)?	☐	☐
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.	☐	☐
5. Have you experienced any of the following symptoms within the last 14 days? • 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.	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
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.	☐	☐
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.		
8. Travel Declaration a. Are you currently residing outside of India? If yes, please provide your details:	☐	☐
b. Have you travelled abroad in the past 14 days? If yes, please provide your travel details over the past 14 days:	☐	☐
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:	☐	☐

COUNTRY	CITY	DATE OF TRAVEL	INTENDED DURATION

COUNTRY	CITY	DATE OF TRAVEL	DATE DEPARTED

COUNTRY	CITY	DATE OF TRAVEL	INTENDED DURATION

Please select Yes or No against all the options.

If answer to question 6 is YES, then share its details in question 7.

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0124-270-9046

Email
customerservices@avivaindia.com

Share details and provide Vaccination certificate if your answer to this question is "YES".

	Yes	No
9. COVID19 Vaccination details 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 ? 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.

In case of a manually filled form, Policy owner to sign here.

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).

Applicant Signature

Signed at ..... on this day ..... of ..... , ...

Declaration details required. Please fill as: Signed at (place) on this day (DD) of (MM), (YYYY).

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 है।

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

If signature is in vernacular language (i.e. other than English) or policyholder is illiterate then please fill declarant's details and provide photo ID proof.

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