



	Yes	No	Yes	No
5. Kidney or Urinary Bladder, Stones, Prostate Disorder or Genitourinary Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Multiple Sclerosis, Epilepsy, Tremor, Numbness, Double Vision or Giddiness, Paralysis, Mental or Nervous Illness (including depression)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Asthma, Bronchitis, Pneumonia, TB or any other respiratory or Lung disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Birth disorders, Anemia, Leukemia, disorder of Lymph Glands or other Blood disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Disorder of Skin, Back, Muscle, Joints, Arthritis, Gout, Bodily Deformity, Amputation, Bone Fracture or any other disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Were you or your spouse ever diagnosed with Hepatitis B or C, HIV/AIDS or any other sexually transmitted disease?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Have you ever been tested positive for COVID-19 or hospitalized for COVID infection or its complication or do you have any ongoing complications related to COVID Infection? If "Yes", please provide following details: a. Date of diagnosis _____ b. Were you home quarantined? c. Were you Hospitalized? d. Ongoing complications related to COVID Infection?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* **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 a er fully understanding the contents.

Declarant's Name _____ Declarant's Signature _____

Declarant's Address & Contact Number _____

