

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

Policy number Proposal number	Name of Life Insured Date of birth	____/____/____ Gender <input type="checkbox"/> <input type="checkbox"/> DD MM YY Male Female
Contact number	Name of Second Life Insured	
Email	Date of Birth Second Life Insured	____/____/____ Gender <input type="checkbox"/> <input type="checkbox"/> DD MM YY 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, EP, 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proposal on your life or an application for revival of policy on your life made to this or any other insurer ever been withdrawn or dropped, deferred or declined, accepted with an extra premium or lien or terms other than those proposed?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"/>
<b>For Female Lives only:</b>		
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"/>
<b>If answer to the above questions is 'Yes' except for Q1A, Please provide full details in box below and provide related documents "</b>		

**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	
<b>A.</b> 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>B.</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"/>

v.	Colitis or any other stomach, bowel or bladder problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
vi.	Multiple sclerosis, epilepsy, tremor, numbness, double vision or giddiness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
vii.	Mental or nervous illness (including depression) lasting for more than 3 months and/or requiring more than 10 consecutive days off work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
viii.	Asthma, bronchitis, pneumonia, TB or any other respiratory or lung disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ix.	Ulcer, chronic diarrhoea, hepatitis or jaundice?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
x.	Congenital disorder, anemia, bleeding or blood disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xi.	Reproductive organ or prostate disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xii.	Arthritis, gout or joint pain, muscle, bone fracture or disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xiii.	AIDS or AIDS related complex or test indicating presence of HIV?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xiv.	Any other illness, surgery or injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xv.	Do you have any bodily deformities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xvi.	Do you have any health symptoms or complaints for which a physician has not been consulted or treatment received? eg: persistent fever, unexplained weight loss, loss of appetite, pain, swelling etc.?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C. Has there been any death or illness in your immediate family (Parents, wife/husband, brothers, sisters or children)?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D. 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"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
E. Has there been any change in your mode of life/habits and occupation?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
F. Do you have infomed policies wherein the Sum Assured is greater than 25 lacs?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>G. For Female Lives only:</b>					
iii.	Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
iv.	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"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
v.	Have you had, or do you have any gynecological problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>If answer to the any of the above questions is 'Yes', please provide full details below along with related Documents</b>					

I/We \_\_\_\_\_ do hereby declare that the above statements and answers are true in all particulars and agree & declare that these statements & declaration along with any proposal for insurance under the lapsed policy, shall be the contract of revival of the lapsed policy, between me and Aviva Life Insurance and that if any untrue avement be contain therein, the said contract shall be absolutely null and void and all money which shall have paid in respect thereof shall stand forfeited to Aviva Life Insurance.

Date & Place	Signature of the Life Insured	Signature of the Joint Life insured
	Signature of the proposer (If different from Life Assured)	

Declaration by the person filling in the form (in case of signature in vernacular language, thumb impression and/or in case the proposal has not been filled in by the proposer).

Signature of declarant*	Date & Place	Name & address of declarant