

To be completed seperately including Questionnaire form for each insured person. (If more than one insured Personal required to be covered please obtain addition forms from the company)

<p>1. Name of the Insured Person _____</p> <p>2. Address _____ _____ _____</p> <div style="display: flex; align-items: center; margin-left: 100px;"> <div style="border-bottom: 1px solid black; width: 100px; margin-right: 5px;"></div> <table border="1" style="border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> </div> <p>State/ U. Territory</p> <p>3. Sex (Stricke out Whichever is not applicable) : Male/ Female</p> <p>4. Relationship with the proposer :</p> <p>5. Date of Birth and age :</p> <p>6. (a) Average monthly income Rs. : Income Tax PAN No.</p> <p>(b) Income Tax Pan</p> <p>7. Profession/ Occupation/ Trade or Business (Please describe fully with nature of duties) : Pin Code : Tel. No. : State/ U. Territory :</p> <p>8. Name and address of the Medical Practitioner, his qualification & Telephone No. if any. Pin Code : Tel. No. : State/ U. Territory :</p> <p>9. Medical Practitioner's Regn. No. :</p> <p>10. Are you at present or any other time in the past covered under any other Insurance : Type (PA, Cancer Insurance, Hospitalisation Insurance or other Medical Insurance) If so, give particulars of - (a) Insurer, policy No. and period of cover : (b) Claim Amt. Recd/ receivable :</p> <p style="text-align: center;">Period From To</p> <p>11. Any proposal for this Insurance or any other similar insurance refused or cancelled or higher premium charged, if so give details :</p>								<p>FOR OFFICE USE</p>

12. Medical history to be completed by the Proposer/ insured person :
- Please answer the following questions in yes or no (a dash is not sufficient) and give full details if answer is yes. :
- 12.1 Are you in good health and free from physical and mental disease of infirmity or medical complaints? : -----
- 12.2 If not in good health give full details : -----
13. Have you ever suffered any of the disease/illness? If yes, give details. : -----
- (a) any nervous, mental or psychiatric disease : -----
 - (b) Slipped disc or other spinal disorder or (fainting episode, blackout, fit) paralysis of any kind. : -----
 - (c) High blood pressure, heart diseases, including ischaemic heart disease, other circulatory disorder etc. (rheumatic fever) : -----
 - (d) Fistula, piles, hernia, varicose veins : -----
 - (e) Any disease of the bones or joints including rheumatic disease. : -----
 - (f) Disease of uterus, ovaries or breast or any specific gynaecological disorders. : -----
 - (g) Any respiratory or allergic disease : -----
 - (h) Any disorder of the stomach, ulcer, bowel or gall bladder, kidney stones etc. : -----
 - (i) Any cancer, malignant growth, boil cyst or wound etc. which does not heal or improve despite treatment. : -----
 - (j) Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations. : -----
 - (k) Any complaint or tendency that may necessitate such consultation or treatment in the future : -----
 - (l) Any dimness of vision/ cataract : -----
 - (m) Any disease of ears of difficulty or interference with hearing : -----
 - (n) Diabetes or any urinary diseases : -----
 - (o) Any other illness or disease or accident or operation sustained by you : -----

- (14) Have you ever suffered from dental problems? Yes/ No.
- (p) If yes, specify same :
- (q) When were you treated Last for same :

15. Give particulars in table below of any other illness or disease or accident or operation sustained by you in the past.

Nature of illness/disease injury and treatment received	Date first treated	Name of attending medical practitioner, surgeon with his address and Telephone No.	Whether fully cured
1.			
2.			
3.			
4.			

16. Are there any additional facts affecting the proposed insurance which should be disclosed to Insurers?
17. Please give details of any knowledge of any positive existence or presence of any ailment, sickness or injury which may require medical attention.
1.
2.
3.
4.

18. Please specify Sum Insured opted : Rs.

I hereby declare and warrant that the above statements are true and complete. I consent authorise the Insurers to seek medical information from any Hospital/ Medical Practitioner who has at any time attended or may attend concerning any disease or illness which affects my physical or mental health. I agree that his proposal shall from the basis of the contract should the insurance be effected. If after the insurance is effected, it is found that the statements, answers or particulars stated in the Proposal form and its Questionnaires are incorrect or untrue in any respect, the Insurance Company shall incur no liability under this insurance.

I have read the Prospectus and I am willing to accept the coverage subject to the terms, conditions and exceptions prescribed by the Insurance Company herein.

Signature :

Date

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DD

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MM

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YY

Place :