

## GOOD HEALTH DECLARATION

(To be completed by Life Assured / Proposer)

Policy Number

Date:

### SECTION 1: INSURED IDENTIFICATION

Name of the Life Assured

Gender  Male  Female Date of Birth

Marital Status  Married  Single  Divorced  Widowed

Occupation  Self Employed  Employed  Army  Others

Name of Employer / Business Owned

Annual Income

Briefly describe normal duties

Nationality  Indian  Non Resident Indian (NRI)  PIO  Foreign National  
if not Indian, state the country of residence

Email ID

Contact No.  Mobile

### SECTION 2: HEALTH STATUS

#### Health Record of Life Assured

Height:  Cms Weight:  Kgs

In the past 6 months, has your body weight changed by more than 5 Kg?  Yes  No

If yes, please state cause of a change in weight

Visible identification mark if any

Have you ever suffered from or have been diagnosed with any of the following conditions?  Yes  No

If yes, please tick the relevant box below, attach a relevant questionnaire and fill the details below:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Hypertension / High Blood Pressure                 | <input type="checkbox"/> Chest Pain / Heart Attack                              | <input type="checkbox"/> Any other heart disease / problems         |
| <input type="checkbox"/> HIV Infection / AIDS                               | <input type="checkbox"/> Diabetes / High Blood Sugar                            | <input type="checkbox"/> High Cholesterol                           |
| <input type="checkbox"/> Anxiety Disorders/Stress                           | <input type="checkbox"/> Disease of reproductive organs                         | <input type="checkbox"/> Kidney / Renal Problems                    |
| <input type="checkbox"/> Stroke / Paralysis                                 | <input type="checkbox"/> Disorder of any glands (e.g. Thyroid)                  | <input type="checkbox"/> Musculoskeletal or Joint disorders         |
| <input type="checkbox"/> Digestive disorders (e.g. ulcer, colitis)          | <input type="checkbox"/> Skin disorder  | <input type="checkbox"/> Ailment / injury                           |
| <input type="checkbox"/> Eyes / Ear / Nose / Throat disorder                | <input type="checkbox"/> Absence from work for more than 7 days                 |   |
| <input type="checkbox"/> Asthma / Tuberculosis or<br>an other lung disorder | <input type="checkbox"/> Jaundice / Hepatitis B or C or<br>other liver problems | <input type="checkbox"/> Cyst of any kind /<br>Tumour Growth/Cancer |
| <input type="checkbox"/> Any blood disorder<br>(e.g. Anemia / Thalassemia)  | <input type="checkbox"/> Any other <input type="text"/>                         |   |

Illness, Injury or tests	Date Commenced	Type of treatment	Duration of Illness/ injury	Date of last symptoms	Current Condition	Full name and address of doctor or hospital (if any)

In case of major sickness/operation, the special questionnaire, hospital, doctor's report has to be submitted.

**General questions**

- 1. Do you have intention to travel abroad.  Yes  No
- 2. Has any proposal for insurance on your life ever being declined / postponed / accepted with modified terms.  Yes  No
- 3. Are you a politically exposed person?  Yes  No  
If Yes, please provide details \_\_\_\_\_

**Life Style**

- i. Do you consume any alcoholic drink? If yes, indicate quantity consumed (Glass/Peg) per week  Yes  No  
 Beer \_\_\_\_\_ (Glass/Peg)    Wine \_\_\_\_\_ (Glass/Peg)    Hard Liquor \_\_\_\_\_ (Glass/Peg)
- ii. Do you smoke cigarette or consume tobacco in any form? If yes, indicate quantity consumed per day  Yes  No  
 Cigarettes \_\_\_\_\_ (no)    Tobacco \_\_\_\_\_ (mg)
- iii. Do you consume narcotics or any other drug not prescribed by a physician?  Yes  No  
If yes, Name \_\_\_\_\_ Since when \_\_\_\_\_
- iv. Do you engage or have you any prospect or intention of engaging in aviation other than as a passenger on a regular airline or any other hazardous occupation, sports, hobbies or pursuits, eg. Rock Climbing, Car Racing, Bungee Jumping, Para Gliding etc?  Yes  No  
If yes, fill relevant questionnaire \_\_\_\_\_

**For Female Life Assured only**

- i. Are you pregnant at present?  Yes  No  
If Yes, duration, in weeks \_\_\_\_\_
- ii. Date of last delivery  Yes  No  
|D|D|M|M|Y|Y|Y|Y|
- iii. Any complications, miscarriage, or Caesarian section  Yes  No  
If yes, give details \_\_\_\_\_
- iv. Have you had or have any gynecological problem or been advised to have mammogram, biopsy or operation of the breasts, pelvis or any other gynecological tests?  Yes  No  
If yes, give details \_\_\_\_\_
- v. Maiden Name of Life to be Assured (if married) \_\_\_\_\_

**AGREEMENT**

I / We hereby declare and agree that the above disclosures along with the Statements and the declaration made under the proposal will be the basis of the contract of assurance between me/us and Future Generali India Life Insurance Company Limited, if any statement is found to be untrue or inaccurate or if any fact that might influence the terms of acceptance of this proposal is not disclosed, the contract shall be treated as null and void and all premiums paid till such time the policy is declared void by the Company shall stand forfeited by the company.

Proposer's Signature \_\_\_\_\_ Date |D|D|M|M|Y|Y|Y|Y| Place \_\_\_\_\_

Life Assured's Signature \_\_\_\_\_ Date |D|D|M|M|Y|Y|Y|Y| Place \_\_\_\_\_

**DECLARATION FOR POLICYHOLDER SIGNING IN VERNACULAR LANGUAGE / THUMB IMPRESSION**

Name of Witness \_\_\_\_\_ Contact no. \_\_\_\_\_

Witness Address \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Signature / Thumb impression of Policyholder \_\_\_\_\_

Date |D|D|M|M|Y|Y|Y|Y| Date |D|D|M|M|Y|Y|Y|Y|

Place \_\_\_\_\_ Place \_\_\_\_\_

## ACKNOWLEDGEMENT

This is to acknowledge the receipt of application for Revival of policy.

Policy No

CLS ID

Date

FG Stamp