

Application Form

(Please fill the form in BLOCK letters)

Term of the Policy: 5 years only (Renewable)

Customer ID No.:

Policy No.:

Office Code:

Campaign Code:

Agent/Specified Person/Broker/Employee Name:

Agent/Specified Person/Broker/Employee Code:

STEP 1A PERSONAL DETAILS OF PROPOSED INSURED

Name: First Name Middle Name Last Name Gender: M F

Father's/Husband's Name: First Name Middle Name Last Name

Address 1/Village:

Address 2/PO:

Address 3/PS: Landmark:

City: District: State:

PIN Code: Nationality:

Marital Status: Single Married Widowed Divorced Date of Birth: DD MM YY YY YY

Tel. (O): Tel. (R): Mobile:

E-mail: Maiden Name: (in case of married women)

Identity Type: Identity Number: (Passport No.)

Occupation: Exact Nature of Daily Duties:

Business Address:

Annual Income (in Rs.): Name of the employer:

Correspondence Address: Residential Business Which hand do you use predominantly? Left Right

STEP 1B PERSONAL DETAILS OF APPLICANT, IF OTHER THAN PROPOSED INSURED

Name: First Name Middle Name Last Name Gender: M F

Marital Status: Single Married Widowed Divorced

Address 1/Village:

Address 2/PO:

Address 3/PS:

City: State: PIN Code:

Business Address:

Identity type: Identity number:

Name of the employer: Annual Income (in Rs.):

Relationship with Proposed Insured:

STEP 2 DETAILS OF NOMINEE

Name (underline Surname/Family Name & expand any initials in the following sequence: Surname/Family Name, First Name, Middle Name)	Relationship with Insured	Age	Identity Type & Number

STEP 3 DETAILS OF APPOINTEE (Applicable only in cases where the nominee is below 18 years.)

Name	Relationship with Insured	Age	Identity type & number	Signature of Appointee

STEP 7A HEALTH QUESTIONS

3. Have you ever been diagnosed, treated or sought treatment or advice for cancer (including skin cancer or ulcerated moles), tumour, leukaemia, lumps or growths of any kind?	Yes	No
4. Have either of your natural parents or any siblings died or suffered from cancer (including leukaemia) before the age of 60?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been declined, deferred or accepted at special terms under a life, accident, medical or other health related insurance?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any of the following (for Critical Illness Benefit only):		
a. Diabetes, stroke, chest pain, heart attack, heart disease, raised cholesterol, high or low blood pressure;	<input type="checkbox"/>	<input type="checkbox"/>
b. Any disease or disorder of the nervous system, respiratory system, digestive system, kidney disorder, hepatitis (including hepatitis B carrier), blood or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
c. Any disease or disorder related to HIV infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
d. Any physical disability or mental impairment not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>
For Accidental Death Benefit		
7. Do you have any physical defects, impairment, deformities and/or any condition affecting mobility, sight and/or hearing?	<input type="checkbox"/>	<input type="checkbox"/>

STEP 7B OTHER DETAILS

Have you ever been convicted of any criminal proceedings under any court of law in India or abroad? If yes please provide details, _____	Yes	No
_____	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE COMPLETE STEPS 8 AND 9 IF SUM ASSURED OF TERM LIFE COVER EXCEEDS RS. 400,000 OR ANY OTHER BENEFIT IS OVER RS. 800,000, OTHERWISE GO TO STEP 10.

STEP 8 CURRENT/PREVIOUS INSURANCE DETAILS

Name of Company	Sum Assured				Issue Date
	Life	Critical Illness	Accident	Hospital	
1. Are you now a member of any military force, engaged or are considering engaging in any hazardous sports or events (e.g. motor racing, climbing, scuba diving etc.) or flying in any aerial device other than as a fare paying passenger on a regularly scheduled airline or travel overseas than for vacation or holiday?					Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you EVER had an application for life, accident, medical, or health related insurance offered with restricted benefits or with an increased premium, or made any claim under any such policy of insurance?					Yes <input type="checkbox"/> No <input type="checkbox"/>
If answer to any of the questions above (1 or 2) is "yes", please provide details:					

STEP 9 HEALTH DETAILS OF PROPOSED INSURED

3.a) Height	cm/feet
b) Weight	kg/lb
c) Has there been any change in your weight in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', please state amount change and cause if known.	Amount change: Cause:
4. Have you EVER HAD any of the following:	Yes No
a. Fits, recurrent headache, paralysis, faints or any other disease or disorder of the brain, spinal cord or nerves?	<input type="checkbox"/> <input type="checkbox"/>
b. Depression, anxiety, schizophrenia or any other mental or nervous disorder?	<input type="checkbox"/> <input type="checkbox"/>
c. Thyroid disorder?	<input type="checkbox"/> <input type="checkbox"/>
d. Ear discharge, impaired sight, hearing or speech or any other disorder of ear, eye, nose or throat?	<input type="checkbox"/> <input type="checkbox"/>
e. Asthma, pneumonia, tuberculosis, emphysema, coughing up blood, persistent cough, or any other disorder of the chest or lungs?	<input type="checkbox"/> <input type="checkbox"/>
f. Palpitations, heart attack, or any other disorder of the heart or blood vessels?	<input type="checkbox"/> <input type="checkbox"/>
g. Liver disorder, gall bladder disorder, ulcer, bleeding from the stomach or bowel, haemorrhoids or any other disorder of the digestive tract?	<input type="checkbox"/> <input type="checkbox"/>
h. Bladder disorder, urine abnormality or genital organ disorder?	<input type="checkbox"/> <input type="checkbox"/>
i. Haemophilia or leukaemia?	<input type="checkbox"/> <input type="checkbox"/>
j. Back or neck complaint, arthritis, gout?	<input type="checkbox"/> <input type="checkbox"/>

STEP 9 HEALTH DETAILS OF PROPOSED INSURED (contd...)

k. Any illness that has caused you to be absent from work for a continuous period of 7 days or more?	Yes	No
5. Have you or your spouse received medical advice, testing or treatment in connection with sexually transmitted disease or HIV infection or suffered from prolonged weight loss, diarrhoea, enlarged glands, or unusual skin lesion or been advised to abstain from donating blood?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you consulted a doctor or any other medical facility for investigation or diagnostic tests (such as x-ray, ultrasound, CT scan, biopsy, ECG, blood or urine, etc) in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had any other illness, injury, operation or abnormality not mentioned under any question above which is recurrent or has symptoms persisting for more than 7 days?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any symptoms or condition for which you intend to attend a doctor in the future?	<input type="checkbox"/>	<input type="checkbox"/>
9. Female Insured/Applicant only:		
a. Are you now pregnant? If 'yes', please state expected delivery date <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YY"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever suffered from any complication during a previous pregnancy or delivery?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you suffered from irregular menses?	<input type="checkbox"/>	<input type="checkbox"/>

If answer to any of the questions above in STEP 9 (Questions 4 to 9) is 'yes', please give full details (Diagnosis, Dates, Investigations, Results, Treatment & Current Condition), noting the question number.

Question No		
10. Name and Address of your physician (Western Medical Practitioner). Please provide registration number, date, reason and result of last consultation.		Insured's Doctor:

STEP 10 DECLARATION AND AUTHORISATION

You have to disclose in this application ALL material facts which shall form the basis of our contract, otherwise the policy issued may be void or voidable. If you are in doubt whether a fact is material, please disclose it.

Declaration & Authorisation: I/We hereby declare and agree that (a) I/We have read the application or the same was interpreted to me/us, and the answers entered in the application are mine/ours; (b) I/We hereby certify, on behalf of myself/ourselves and behalf of any person who may have or claim any interest in the said Policy, that each of the above answers is full, complete and true and I/We understand that Tata AIG Life Insurance Company Ltd. (hereafter called "the Company") believing them to be such, will rely and act on them, otherwise the proposed application may be void; (c) Such application shall not be considered as effected by reason of any money paid, or settlement made in payment of or on account of any premium, until this application is received by the Company during the life time of the Insured and is finally approved by an authorized officer of the Company; (d) if my/our application be accepted by the Company, the Incontestability and Suicide Provision thereof shall have effect from the approval date of my/our application.

Furthermore, I hereby irrevocably authorize (a) any organization, institution, or individual that has any record of knowledge of my/the Insured's health and medical history or any treatment or advice that has been or may hereafter be consulted or other personal information to disclose to the Company such information. This authorization shall bind my/the Insured' successors and assigns and remain valid notwithstanding my/the Insured's death or incapacity in so far as legally possible; and (b) the Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and test to underwrite and evaluate my/the Insured's health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, Acquired ImmunoDeficiency Syndrome (AIDS), infection by any Human Immunodeficiency Virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites. A photocopy of this authorization shall be valid as the original. I also agree and undertake that a) if there is any material change in my circumstances, including but not limited to, changes in my health, employment, financial circumstances, arrest or being charged with a criminal offence, non-standard acceptance or rejection of a life insurance application, prior to the acceptance of the company of this application for insurance, I will immediately notify the company of such change in writing, and b) the company will take into account any such change in circumstances in deciding whether to reject or accept this application, and c) failure to notify the company in this manner shall, at the company's discretion, render this policy void and all moneys which shall have been paid in respect thereof shall stand forfeited to the company.

INSURANCE ACT 1938, Section 45: No policy of life insurance effected before the commencement of this Act shall after expiry of two years from the date of commencement of this Act and no policy of life insurance effected after the coming into force of this act, shall after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policyholder and that the policyholder knew at the time of making it that the statement was false or that it suppressed facts, which it was material to disclose. Provided that nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.

Cancellation right and refund of premium (Free Look Period): I understand that I have the right to cancel and obtain a refund of any premium(s) paid by giving written notice. Such notice must be signed by me and received directly by the Company within fifteen (15) days from the date of receipt of the policy.

Commencement of cover: I/We understand that the cover applied for under this application will commence after approval of my/Our application and receipt of the required premium by the Company.

INSURANCE ACT 1938 Section 41: Prohibition of Rebates. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

ANY PERSON MAKING DEFAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO FIVE HUNDRED RUPEES.

U.S. TAX DECLARATION : " By purchasing this policy and signing below ,I represent I am not a U.S. person for purposes of US federal income tax and that I am not acting for ,or on behalf of ,a US person." A false statement or misrepresentation of tax status by a US person could lead to penalties under US law. If your tax status changes and you become a US citizen or resident, you must notify us within 30 days (US citizens must strike out this clause and initial the change at the left hand side).

Insurance is the subject matter of the solicitation.

Signature of the Proposed Insured:	Date: <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YY"/>	Place: <input style="width:100%;" type="text"/>
Agent/ Specified Person/ Broker/ Employee Signature:	Corporate Stamp: (In case of Specified Person/Broker)	<input style="width:100%;" type="text"/>
Signature of Applicant		

IN CASE THE PROPOSED INSURED IS ILLITERATE OR IS SIGNING IN VERNACULAR:
 The thumb impression or signature of the Proposed Insured/Applicant should be attested by the agent or a person of standing whose identity can easily be established and this declaration should be made by him.

I _____ (name) with _____ (identity type) _____ (identity number) hereby declare that I have explained the contents of the application form to the Proposed Insured/Applicant in _____ language and that I have read out to the Proposed Insured/Applicant the answers to the questions dictated by the Proposed Insured/Applicant and that the Proposed Insured/Applicant has affixed his thumb impression on the application form after fully understanding the contents thereof.

Signature of Witness/SANCHALAK : _____

Please affix thumb impression here

FOR OFFICE USE ONLY

Policy No.: <input style="width:100%;" type="text"/>	Agent/Specified Person/Broker/Employee Code: <input style="width:100%;" type="text"/>	Office Code: <input style="width:100%;" type="text"/>
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This product is underwritten by Tata AIG Life Insurance Company Ltd.

Unique Reference No.: L&C/Abw/2008/Sep/1438 UN: 110N039102 PR&F00295