



**STEP 2A DETAILS OF NOMINEE** (Applicable only if Proposed Insured and Applicant/Policyholder is the same person)

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 2B 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 3 INSURANCE APPLIED FOR**Term of policy:  10 years  15 years  20 years  25 years  30 yearsPremium paying term:  3 years  5 years  7 years  10 years  Full premium paying term

Particulars	Amount of Insurance (in Rs.)
Basic Plan (Sum Assured)	
Accidental Death Benefit	
Accidental Death and Dismemberment <input type="checkbox"/> Long Scale <input type="checkbox"/> Short Scale	
Waiver of Premium for 15, 20, 25 and 30 year terms	
5-Year Renewable Term	
10-Year Term	
15-Year Term	
20-Year Term	
25-Year Term	
Critical illness <input type="checkbox"/> Accelerated Benefit <input type="checkbox"/> Lump sum Benefit	

Mode of Payment:  Annual  Semi-annual  Quarterly  MonthlyPremium Rs.  + Service Tax<sup>^</sup> Rs.  = Total Payment Rs.  for  months initial deposit.<sup>^</sup>Service tax is payable on life insurance premium as per section 65(105)(zx) of Finance Bill (No.2), 2004 at the applicable rates as per circular number 80/10/2004-S.T. dated 17-9-2004 issued by the Govt. of India, Ministry of Finance and subsequent directions issued by the authorities from time to time.**STEP 4 TO BE COMPLETED BY INSURED IN ALL CASES**

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 other than for vacation or holiday?	Insured Yes <input type="checkbox"/> No <input type="checkbox"/>	Applicant Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you EVER had an application for life, accident, medical or health related insurance refused, postponed or offered with restricted benefits or with an increased premium or made any claim under any such policy of insurance?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

If answer to any of the questions above (4.1 or 4.2) is 'Yes', please provide details.

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3. Do you have any existing insurance and/or concurrent application for insurance on your life? If 'Yes', please provide details. Indicate (I) for Insured or (A) for Applicant.	Insured Yes <input type="checkbox"/> No <input type="checkbox"/>	Applicant Yes <input type="checkbox"/> No <input type="checkbox"/>
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Name of Company	Sum Assured				Issue Date
	Life	Critical illness	Accident	Hospital	

**STEP 5 HEALTH DETAILS OF INSURED**

	<b>Insured</b>	<b>Applicant</b>
1. Do you smoke or otherwise use tobacco products or have done so in the last 12 months? If 'Yes', please state type and quantity consumed daily (average). If you have stopped smoking, please state date and reason.	<input type="checkbox"/> Yes <input type="checkbox"/> No Type: Quantity:	<input type="checkbox"/> Yes <input type="checkbox"/> No Type: Quantity:
2. a) Height b) Weight c) Has there been any change in your weight in the 12 months? If 'Yes', please state amount change and cause if known.	cm/feet kg/lb <input type="checkbox"/> Yes <input type="checkbox"/> No Amount change: Cause:	cm/feet kg/lb <input type="checkbox"/> Yes <input type="checkbox"/> No Amount change: Cause:
3. Do you drink alcohol? If 'Yes', please state type and quantity consumed per week (average). If you have stopped alcohol, please state date and reason.	<input type="checkbox"/> Yes <input type="checkbox"/> No Type (wine/spirit/beer): Quantity:	<input type="checkbox"/> Yes <input type="checkbox"/> No Type (wine/spirit/beer): Quantity:

**STEP 5 (Continued)**

4. <b>Have you EVER HAD any of the following:</b>	<b>Insured</b>		<b>Applicant</b>	
	Yes	No	Yes	No
a) Stroke, epilepsy, fits, recurrent headache, paralysis, faints or any other disease or disorder of the brain, spinal cord or nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Depression, anxiety, schizophrenia or any other mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Diabetes, thyroid disorders or any other hormone disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) High blood pressure, palpitations, chest pain, raised cholesterol, heart attack, or any other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Hepatitis (including hepatitis B carrier), 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Kidney or bladder disorder, urine abnormality or genital organ disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Anaemia, haemophilia, leukaemia or any other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Back or neck complaint, arthritis, gout, physical disability or other disorder of the bones joints or muscles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Any illness that has caused you to be absent from work for a continuous period of 7 days or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. a) Have you been infected with HIV (Human Immunodeficiency Virus), been diagnosed as having HIV antibodies or suffered from an AIDS related condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last 5 years, have you attended doctor or any other medical facility for investigation or diagnostic tests (such as X-ray, ultrasound, CT scan, biopsy, ECG, blood or urine, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. <b>Female Insured/Applicant only</b>				
a) Are you now pregnant? If 'Yes', please state expected delivery date. Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you suffered from any disorder of the breast or reproductive organs including abnormal smear test(s) and irregular menses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If answer to any of the questions above (5.4 to 5.9) is 'Yes', please give full details (Diagnosis, Dates, Investigations, Results, Treatment & Current Condition), noting the question number and indicate whether the answer relates to Insured (I) or Applicant (A).

Question No.	
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10. Have either of your natural parents or any siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder or depression, tuberculosis or polycystic kidney or other hereditary disease before the age of 65? If 'Yes', please provide details (type of cancer if applicable):						<b>Insured</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Applicant</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
Relationship	Type of Illness	Age at Diagnosis	Current Age (if living)	Age at Death (if deceased)	Relative of Insured	Relative of Applicant			
11. Name and Address of your physician (Western medical practitioner). Please provide registration number, date, reason & result of last consultation.				Insured's Doctor		Applicant's Doctor			
12. Special Request:									
<input type="checkbox"/> Date back to _____ (Day/Month/Year)									
<input type="checkbox"/> Conversion: Sum Assured Rs. _____ from policy number _____									
<input type="checkbox"/> Others: _____									
Company Endorsement Only:									

### STEP 6 DECLARATION & 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 integrated 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 authorised 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 authorise (a) any organisation, 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 authorisation shall bind my/the Insured's 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 Immune Deficiency 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 48:** No policy of life insurance effected before the commencement of this act shall after expiry of two years from the date of commencement of the Insurance 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 (application) 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 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 deemed to 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 (application).

**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 (15) days from the date of receipt of the policy.

**Commencement of cover:** I understand that the cover applied for under this application will commence after approval of my 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 a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus 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/Thumb Impression of Proposed Insured	_____ Signature/Thumb Impression of Applicant	_____ Signature of Agent
_____ Place	_____ Date (Day/Month/Year)	_____ Countersigned by RDW/ADM/ADE

**IN CASE THE PROPOSED INSURED 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: \_\_\_\_\_

Please affix thumb impression here

This product is underwritten by Tata AIG Life Insurance Company Ltd.

**Tata AIG Life Insurance Company Ltd.** (Regn. No. 110)  
 Registered & Corporate office: Peninsula Towers, 6<sup>th</sup> Floor, Peninsula Corporate Park, Ganpatrao Kadam Marg, Lower Parel, Mumbai 400 013.  
 For more information, call the Tata AIG Life 24 hour toll-free helpline at 1-800-11-9966. Visit us at: [www.tata-aig-life.com](http://www.tata-aig-life.com)

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