

Health Certificate



<p>IMPORTANT NOTE</p> <p>1. 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.</p> <p>2. Please complete payor's information if PB is attached for reinstatement or PB is applied (applicable for Juvenile Policy).</p>	<p>Policy No. : <input style="width: 50px; height: 15px; border: 1px solid black;" type="text"/></p> <p>Agent Name : _____</p> <p>Agent Code : _____</p> <p>Office Code : _____</p>
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Application for: Reinstatement Removal/Reduction in Rating Addition of Riders Change in Plan Others

PLEASE WRITE IN BLOCK LETTERS

A. Personal Details		Insured	Payor
Name: Underline Surname/Family name & expand any initials in the following sequence (Surname/Family name, First name, Middle name)			
Sex:		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation:			
Nature of daily duties:			
Correspondence address:			
		City/Village District/State: PIN Code: Telephone : Email ID:	City/Village District/State: PIN Code: Telephone : Email ID:

B. Health details of Life Insured/Proposer		Insured	Payor
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?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Please state the amount of existing or proposed insurance on your life (in Rs.): _____			
4. a) Height _____ cm/feet			
b) Weight _____ kg/lb			
c) Has there been any change in your weight in the last 12 months? If 'Yes', please state amount changed and cause if known. _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. 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
6. 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 _____ Quantity	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Type _____ Quantity
7. Have you EVER HAD any of the following:			
a) Stroke, epilepsy, fits recurrent headache, paralysis, faints or any other disease or disorder of the brain, spinal cord or nerves?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Depression, anxiety, schizophrenia or any other mental or nervous disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Diabetes, thyroid disorders or any other hormone disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Ear discharge, impaired sight, hearing, or speech or any other disorder of ear, eye, nose or throat?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Asthma, pneumonia, tuberculosis, emphysema, coughing up blood, persistent cough, or any other disorder of the chest or lungs?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) High blood pressure, palpitations, chest pain, raised cholesterol, heart attack, or any other disorder of the heart or blood vessels?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Kidney or bladder disorder, urine abnormality or genital organ disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Cancer, tumour, cyst or growth of any kind?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Anaemia, haemophilia, leukaemia or any other blood disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) Back or neck complaint, arthritis, gout, physical disability or other disorder of the bones joints or muscles?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) Any illness that has caused you to be absent from work for a continuous period of 7 days or more?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. 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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. 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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. 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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you have any symptoms or condition for which you intend to attend a doctor in the future?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Female Insured/Applicant only			
a) Are you now pregnant? If 'Yes', please state expected delivery date: <input style="width: 50px; height: 15px; border: 1px solid black;" type="text"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Have you ever suffered from any complication during a previous pregnancy or delivery?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Have you suffered from any disorder of the breast or reproductive organs including abnormal smear test(s) and irregular menses?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. 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): _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If answer to any of the questions above (1 to 13) 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. _____

C. The following to be answered if Life Assured has opted for the below mentioned Riders in the product Health Protector

	Insured	Payor
For Accident Benefit: 1. Do you have any physical defects, impairment, deformities and/or any condition affecting mobility, sight and/or hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
For Cancer Benefit: 2. In the past 10 years have you been diagnosed, treated or sought treatment or advice for cancer (including skin cancer or ulcerated moles), tumour or leukaemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past 5 years have you had any diagnostic tests e.g. Mammogram, X-ray, ultrasound, CT scan, biopsy, blood or urine test for any lump, cyst, tumour, chronic lesions or growths of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. If "Yes" to question 3, did the results warrant further testing, treatment, referral to another doctor or specialist, follow up with your own doctor or future follow-up recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have 2 or more immediate family members (natural parents & siblings) ever been diagnosed below age 60 with cancer, tumour or leukaemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. a) Male Applicant: Has your father been diagnosed with bowel or colon cancer, below age 60? b) Female Applicant: Has your mother been diagnosed with breast cancer, below age 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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 Co. 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 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 Immuno 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 authorisation 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 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. 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 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).

Insurance is the subject matter of the solicitation.

Signature/Thumb Impression of Insured

Date:

(Date of Signing this Health Certificate)

Signature/Thumb Impression of Owner/Payor

Place: _____

Kindly ensure your signature matches with that in the application form.

Validity: 90 days from date of signing the health certificate

Signature of Agent/Witness:

IN CASE THE LIFE INSURED IS SIGNING IN VERNACULAR:

The thumb impression or signature of the Life insured / Policyholder 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 Health declaration to the Life insured / Policyholder in _____ language and that I have read out to the Life insured / Policyholder the answers to the questions dictated by the Life insured / Policyholder and that the Life insured / Policyholder 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.