COVID-19 DECLARATION FORM

ICICI PRUDENTIAL LIFE INSURANCE

Guidelines:
- ✓ This form should contain the details of Life assured
- ✓ Insurance is a contract made in utmost good faith, trusting the proposer and the life assured to disclose all the relevant (material) facts, in response to the questions in this form
- ✓ Validity of this declaration is 30 days from the date of declaration
- ✓ This form can be used for all contract servicing and new business application change requests.

Barcode

Policy No./ Nos: ____________ ____________ ____________ **Date:** D D M M Y Y Y Y

Name of the Life Assured: Mr./Ms./Mrs. First Name Surname

Name of the proposer: (If different from the Life Assured) Mr./Ms./Mrs. First Name Surname

Contact numbers: STD Residence STD Office Ext. ISD Mobile

E-mail ID:

For life policies, please provide details of primary life assured only. For health policies, please provide details of all lives covered.

Please provide the following information:

Sr. No.	Questions	Primary Life Assured Yes	Primary Life Assured No	Spouse Yes	Spouse No	Child 1 Yes	Child 1 No	Child 2 Yes	Child 2 No	Child 3 Yes	Child 3 No
1	**Have you ever been tested positive for COVID-19?** If your answer to the above question is yes, please answer the next question.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1.1	**Are you fully recovered?** If your answer to the above question is yes, please answer the next question.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1.2a	**Date of diagnosis** __________										
1.2b	**Date of recovery** __________										
1.3	**Were you hospitalized for COVID-19 treatment?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	**In the last 1 months have you or any of your family member been self-isolated with symptoms on medical advice? (excluding mandatory government orders to remain at home)**										
3	**In the last 1 month did you have persistent cough, fever, sore throat, nausea, vomiting, diarrhea, difficulty in breathing, loss of smell and taste any other symptoms of coronavirus (COVID-19) and advised to do a COVID test or you/your family member have been in contact with an individual suspected or confirmed to have COVID-19?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	**Do you work in an occupation like health care worker/Corona warrior Include (general practitioners, doctors, hospital doctors, surgeons, therapists, nurses, pathologist, paramedics, pharmacist, ward helpers, individuals working in hospitals/ clinics having novel coronavirus (SARS-CoV-2/COVID-19) Ward) where you have a higher risk to get in close contact with COVID-19 patients or with coronavirus contaminated material?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	**Have you travelled abroad in last 15 days or intend to travel abroad in next 15 days?** If your answer to the above question is yes, please answer the following questions.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.1	**Name of country:** __________										
5.2	**Expected date of arrival in India** __________										
5.3	**Expected date of leaving India** __________										
6	**Have you taken COVID-19 vaccine in last 7 days?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7	**Have you experienced any side effects post COVID vaccination?** If your answer to the above question is yes, please answer the following questions.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.1	**If yes, was hospitalization required to treat side effects?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.2	**Details of side effect experienced** __________										

DECLARATION AND AUTHORISATION

I/We declare that I/We have fully understood the questions in the form and the importance of disclosing all material information while answering such questions. I/We further declare that the answers given by me/us to all the questions in the form and the information given to the Medical Examiner of the Company as to the status of COVID-19 and habits of the Life Assured are true and complete in every respect and that I/We have not withheld any material information or suppressed any material fact. I/ We have made no statement to the Insurance Advisor, Medical Examiner, or any other person associated with ICICI Prudential Life Insurance Company Limited which in any way modifies the answers and statements in this form. I/We undertake to notify the Company of any change in the status of COVID-19 of the Life Assured or as to his occupation subsequent to the signing of this form and before the acceptance of the risk by the company for revival / Addition of Rider/ increase in Life/ COVID-19 Sum Assured

I/We hereby authorize ICICI Prudential Life Insurance Co. Ltd. to conduct screening/ confirmation/ reconfirmation of overall status of the Life Assured including the COVID-19 status through medical examinations which may include Laboratory tests, Cardiac, Radiological investigations and other medical tests including blood tests to detect bacterial/viral/fungal infections. I/We hereby give my/our consent to undergo HIV1/2 test by ELISA method. I am/ We are aware that this test is only for screening purpose and not confirmatory for HIV-AIDS. I/We understood that the Company reserves the right to accept, decline or offer alternate terms on this application.

In order to enable the Company to assess the risk under this application and any time thereafter, I/ We hereby, authorize the past and present employers(s)/ business associates/ medical practitioner/ hospital and medical source/ any life and non-life insurance company/or organisation or Life Insurance Association's medical register to release to the Company and the Company to release to any medical source/ any life and non-life insurance company/or Life Insurance Association or medical register, such details and provide the records of employment/business or other details as may be considered relevant. Information about me/ us may be collected and used by ICICI Prudential Life Insurance Co. Ltd. for the purpose of providing/ offering me/ us promotional material relating to any products and services. I/ We hereby agree that a waiting period as stated in the guidelines and applicable as per the product type, shall be applicable after revival of the policy. I/ We also understand that the terms and conditions including the premium and the benefits payable under the Policy are subject to variation in accordance with the applicable laws. This form shall be a part of my/ our Life/ Health insurance policy contract.

Signature/ thumb impression of the Life Assured

Signature/ thumb impression of the Policyholder (if different from the Life Assured)

Applicable when the Policyholder is illiterate or suffering from disability due to which his/ her capacity for writing is restricted or where the Policyholder has signed in a vernacular language. Note: The statement below must be witnessed by someone other than the advisor/ employee of the Company.

I/ We verify that the contents of the this form have been read over and clearly explained to me/ us and I/We have fully understood them. I/We further certify that the replies in this form have been recorded as per the information provided by me/ us.

Full name of witness/ person filling the form __________ (Relation with Policyholder) __________

Date: D D M M Y Y Y Y

Place: __________

Signature of Witness/ person filling the form

Signature/ thumb impression of the Life Assured/ Policyholder signing in a vernacular language)

COMP/DOC/Jul/2021/27/6165