ICICI PRUDENTIAL LIFE INSURANCE

Health Questionnaire: Organ Disorder

Application No. | | | | | | | | | | | **Abha ID:**

Name of Proposer (Policy Owner): _____

Important note:

This questionnaire is a part of your application and is required for further analysis of your above-mentioned policy application.

It is mandatory to provide accurate and complete occupation details as required in the questionnaire below. Suppressing occupation related information or providing incorrect information may impact the claims payout.

A. Lung disorders - Asthma, Tuberculosis, Chronic Cough, Chronic Bronchitis, Emphysema, Pneumonia or any other Respiratory Disorders **Yes** ☐ **No** ☐

a) Tuberculosis Yes ☐ No ☐

1. When were you diagnosed with Tuberculosis? (Please mention date or month & year of diagnosis.)*

2. What organs were involved?*

☐ Lungs ☐ Intestine ☐ Brain ☐ Spinal Cord ☐ Bones ☐ Lymph Nodes ☐ Any Other

3. For how long did you take the treatment?*

☐ Less than 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ More than 12 months

☐ No treatment taken

4. When was the treatment completed? (Please mention date or month & year when the treatment was completed. Share us the copy of consultation/ follow-up report till date, investigation report under upload section provided)*

5. Have you undergone any surgery or was hospitalized for the same?* Yes ☐ No ☐

Hospitalisation details - Please mention hospital name, date of admission and date of discharge, whether admitted in ICU. Share us the copy of all medical reports including consultation till date, investigation report, discharge report if any under upload section provided*

6. Any complication or recurrence after completion of the treatment/ surgery?* Yes ☐ No ☐

Please mention exact complication*

b) Asthma, Chronic Cough, Chronic Bronchitis, Emphysema, Pneumonia or any other Respiratory Disorders Yes ☐ No ☐

1. Please state the exact diagnosis.*

☐ Asthma ☐ Chronic Cough ☐ Chronic Bronchitis ☐ Pneumonia ☐ Emphysema ☐ Sarcoidosis

☐ COPD ☐ Any Other

Please specify exact diagnosis.*

2. When was this condition initially diagnosed? Please mention date or month & year of diagnosis*

3. **Have you been admitted to hospital for this condition?*** Yes ☐ No ☐

Hospitalisation details - Please mention hospital name, date of admission and date of discharge, whether admitted in ICU. Share us the copy of all medical reports including consultation till date, investigation report, discharge report if any under upload section provided*

4. **Confirm frequency of Symptoms related to respiratory disease.***

☐ Daily ☐ Weekly ☐ Monthly ☐ Seasonal

5. **Do you have symptoms which wakes you from sleep?*** Yes ☐ No ☐

Please describe the symptom*

6. **Please provide details of your treatment taken.***

☐ Treatment With Inhaler ☐ Treatment With Oral Medications ☐ Treatment With Injectables

Treatment With Inhaler - (Inhaler details : name of medicine & dosage. Share us the copy of consultation/ follow-up report till date, investigation report under upload section provided)*

Treatment With Oral medications - (Oral medication details: name of medicine & dosage. Share us the copy of consultation/follow-up report till date, investigation report under upload section provided)*

Treatment With injectables (Injectables details : name of medicine & dosage. Share us the copy of consultation/ follow-up report till date, investigation report under upload section provided)

7. **What is the level of your exercise tolerance?** (Mention distance, which you can walk and number of stairs you can climb without causing breathlessness)*

8. **Has any investigation for lung test like CT Scan, PFT, CXR been done in last 2 years?*** Yes ☐ No ☐

Examination details - Name of the test, Date of test and its result. Share us the report copy under upload section provided*

B. Genitourinary Disorders related to Kidney (including Kidney failure), Prostate, Urinary system or any complications such as, Disorder of Cervix, Uterus, Ovaries, Breast, Breast Lump/Cyst/etc **Yes ☐ No ☐**

a) Genitourinary Disorders related to Kidney (including Kidney failure), Prostate, Urinary system or any complications such as, Disorder of Cervix, Uterus, Ovaries, Breast, Breast Lump/Cyst/etc Yes ☐ No ☐

1. **Have you ever suffered or currently suffering from any disease or infection of the kidneys, urinary tract or prostate issues? (Select all that applies)** (Please mention date or month & year of diagnosis.)*

☐ Tumour ☐ Urethritis ☐ Kidney stones ☐ Renal Cyst ☐ Enlarged Prostate

2. **Any other Kidney disease or genitourinary disorder?*** Yes ☐ No ☐

Specify exact diagnosis/ complication*

3. **When was it initially diagnosed?***

Please mention date or month & year of diagnosis.*

4. **Are you still taking treatment of any kind?** Yes ☐ No ☐

Treatment details - Please mention prescribed by Dr's name, date of last consultation, name of the medicine and dosage. Share us the copy of consultation/ follow-up report till date, investigation report under upload section provided *

5. **Have you undergone any surgery?*** Yes ☐ No ☐

Surgery details - Please mention hospital name, name of the surgery, date of admission and date of discharge. Share us the copy of all medical reports including consultation till date, investigation report, discharge report if any under upload section provided.*

6. **Have you now fully recovered?*** Yes ☐ No ☐

b) Disorder of Cervix, Uterus, Ovaries, Breast, Breast Lump/Cyst/etc Yes ☐ No ☐

C. Gastro - Intestinal disorder like Recurrent Indigestion, Pancreatitis, Colitis, Mouth/ Stomach or Duodenal Ulcers etc. **Yes ☐ No ☐**

1. **Are you suffering from gastro- intestinal disorder?***

☐ Pancreatitis ☐ Ulcerative Colitis ☐ Crohn's Disease ☐ Ulcer ☐ Gastritis ☐ Any Other

Please specify exact Gastro Intestinal condition*

2. **When was you initially diagnosed with above mentioned medical condition?***

Please mention date or month & year of diagnosis.*

3. **Are your symptoms related to any particular factor, e.g. stress, alcohol, diet, etc.?*** Yes ☐ No ☐

Please specify exact details*

4. **Have you been prescribed or currently taking medication for Gastro intestinal disorder?*** Yes ☐ No ☐

Treatment details - Please mention prescribed by Dr's name, date of last consultation, name of the medicine and dosage. Share us the copy of consultation/ follow-up report till date, investigation report under upload section provided*

5. **Have undergone any investigations (Ultrasound, blood test, endoscopy etc.), hospitalization, or surgery for this condition?*** Yes ☐ No ☐

Examination details - Name of the test, Date of test and its result.

Note: Share us the copy of all medical reports including consultation till date, investigation report, discharge report if any under upload section provided

6. **Have you been hospitalised with above mentioned condition?*** Yes ☐ No ☐

Hospitalisation details - Please mention hospital name, date of admission and date of discharge, whether admitted in ICU. Share us the copy of all medical reports including consultation till date, investigation report, discharge report if any under upload section provided*

7. **Have you suffered from any complications secondary to this condition?*** Yes ☐ No ☐

Specify exact diagnosis/ complication*

D. Liver disorders like Liver disorders, Cirrhosis, Jaundice, Hepatitis B or C **Yes ☐ No ☐**

1. **Are you suffering from Liver disorder ? *** Yes ☐ No ☐

☐ Liver Cancer ☐ Cirrhosis of Liver ☐ Jaundice ☐ Hepatitis B ☐ Hepatitis C ☐ Fatty Liver

☐ Any Other

Specify exact liver disorder*

2. **When was it initially diagnosed?***

   Please mention date or month & year of diagnosis.*

3. **Have you been prescribed or currently taking medication for liver disorder?*** Yes ☐ No ☐

   Treatment details - Please mention prescribed by Dr's name, date of last consultation, name of the medicine and dosage. Share us the copy of consultation/ follow-up report till date, investigation report under upload section provided*

4. **Have u been hospitalised with above mentioned medical condition?** Yes ☐ No ☐

   Hospitalisation details - Please mention hospital name, date of admission and date of discharge, whether admitted in ICU. Share us the copy of all medical reports including consultation till date, investigation report, discharge report if any under upload section*

☐ I hereby declare that all answers provided above are, to the best of my knowledge, true and that I have not withheld any information that may influence the assessment or acceptance of this application. I also agree that the above questions and answers shall form part of the proposal form of insurance made by me to the Company.

Place: _____

Date: _____

_____

Signature of the Life to be Assured / Proposer