ICICI PRUDENTIAL LIFE INSURANCE

Health Questionnaire

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.

PHYSICAL DEFECT (PHYSICAL DEFORMITY/ HANDICAP, CONGENITAL ABNORMALITY)

Yes ☐ **No** ☐

Physical Deformity/Handicap, Congenital Abnormality

Yes ☐ **No** ☐

1. **Please confirm, has the deformity affected.***

   ☐ One Limb ☐ Two Limb ☐ More Than Two Limbs ☐ Vertebral Spine

   One Limb - Please specify which limbs is affected. Share supporting medical report/ disability certificate if any under upload section provided*

   Two Limb - Please specify which limbs is affected. Share supporting medical report/ disability certificate if any under upload section provided*

   More Than Two Limbs - Please specify which limbs is affected. Share supporting medical report/ disability certificate if any under upload section provided*

   Vertebral Spine - Please specify exact detail related to Vertebral Spine defect. Share supporting medical report/ disabilitycertificate if any under upload section provided*

2. **Whether the deformity is?**

   ☐ Acquired (Secondary to accident/disease, Exposure to medicines/chemicals/other toxic substances, Side effect of surgery/past hospitalization etc)

   ☐ Congenital (since birth)

3. **Are you using any of the following supporting Aid?***

   ☐ Crutches/Stick ☐ Callipers ☐ Wheel Chair ☐ Any Other

   Please specify exact supporting aid*

4. **Is your gait is normal, can you walk fast and run?*** Yes ☐ No ☐

5. **Have you undergone surgery/ amputation?** (e.g TAO, Diabetic Gangrene, Accidental Injury requiring amputation, etc.) Yes ☐ No ☐

   If Yes, specify exact diagnosis/ complication - e.g. Diabetic Gangrene, Accidental Injury requiring amputation, etc.

6. **Are you having paralysis of limbs, is it subsequent to? (Select all that applies)***

- ☐ Old Polio/PPRP (post-polio residual paralysis)
- ☐ Post-Traumatic
- ☐ Post Neurological Disorder/Disease e.g. Stroke

Post-Traumatic: Specify exact Post-Traumatic detail*

Post neurological disorder/ disease e.g stroke: Specify exact Post neurological disorder/ disease detail.*

☐ 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