

17M PERSONAL HEALTH DECLARATION FORM

GUIDELINES:

- Insurance is a contract made in utmost faith, trusting the proposer and the life assured to disclose all relevant (material) facts in response to the questions in this form
- The revival of the policy will be effective from the final underwriting decision date or date of receipt of full premium amount by the company or the receipt of consent for revised premium, whichever is later
- Increase in Sum Assured / Addition of rider will be effective from the next billing cycle
- Addition of life / lives will be effective from the policy anniversary falling after the final underwriting decision or the receipt of full premium by the company or the receipt of consent for revised premium, whichever is later
- Validity of this Personal Health Declaration is three months
- Increase in Sum Assured / Addition of Rider / Addition of Life Assured are product specific. Please refer to the Policy Document for details.



Policy No.: **Date:** DD/MM/YYYY

Name of the Life Assured:
(Primary Life in family floater plans) First Name Middle Name Last Name

Name of the Policy Holder:
 First Name Middle Name Last Name

Address

City State Country PIN CODE

Telephone with STD code **Mobile Number**

Email ID

Policy Inception Date: DD/MM/YYYY **Date of Birth of Primary Life** (For Family Floater plans): DD/MM/YYYY

I, herewith, apply for (Please tick only one):

- Revival of the Policy (For Family floater plans, please share the details of all the lives)
- Increase my Health/ Rider Sum Assured from Rs. _____ to Rs. _____ (allowed for select plans)
- Addition of Rider (allowed for select plans)
- Addition of Life/ Lives to be Assured (in family floater plans)

1. DETAILS OF THE LIFE / LIVES TO BE ASSURED (to be filled only when Life to be Assured is to be added in the existing policy)

	SPOUSE	CHILD 1	CHILD 2	CHILD 3
a) Name	.....	.....	.....	.....
b) Date of Birth	..... DD/MM/YYYY	..... DD/MM/YYYY	..... DD/MM/YYYY	..... DD/MM/YYYY
c) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
d) Marital Status	..... U – Unmarried; M – Married; W – Widower; D – Divorced			
e) Nationality	<input type="checkbox"/> Indian <input type="checkbox"/> Non- Indian	<input type="checkbox"/> Indian <input type="checkbox"/> Non- Indian	<input type="checkbox"/> Indian <input type="checkbox"/> Non- Indian	<input type="checkbox"/> Indian <input type="checkbox"/> Non- Indian
f) Residential Status	<input type="checkbox"/> I <input type="checkbox"/> N	<input type="checkbox"/> I <input type="checkbox"/> N	<input type="checkbox"/> I <input type="checkbox"/> N	<input type="checkbox"/> I <input type="checkbox"/> N
	I – Resident Indian, N – Non- Resident Indian			
g) Age Proof	..... Passport – PSPT ; Driving Licence – DL ; School/ College Certificate – SC ; Others - Pls specify			
h) Education	..... Uneducated – UEDU ; Below 10th – <SSC ; 10th – SSC ; 12th – HSC ; Graduate – GRAD ; Post Grad – PGD ; Diploma – DIP			
i) Qualification	..... Manager – M ; Chartered Accountant – C ; Doctor – D ; Engineer – E ; Advocate – L ; Others (specify)			
j) Occupation	..... Salaried – SP ; Business – BSEM ; Professional – PROF ; Student – STDN ; Housewife – HSWF ; Retired or Pensioner – RETD ; Self Employed – SELF ; Agriculture – AGRI ; Others – OT			
k) Organization Type	..... MNC; Public Ltd; Private Ltd; Partner or Proprietor; Govt; Trust; Others (specify)			
l) Name of Org	.....		
m) Years in Current job	.....		
n) Annual Income	.....		

2. DETAILS OF THE RIDERS TO BE ADDED

Rider Name	Term (years)	Sum Assured (Rs.)	Premium (Rs.)

3. PERSONAL DETAILS OF THE LIFE / LIVES TO BE ASSURED

* For Single Life plans, please fill the details under Primary Life only. For Family Floater plans, provide details for all the lives.

	Primary Life	Spouse	Child 1	Child 2	Child 3	Primary Life		Spouse		Child 1		Child 2		Child 3		
	A. Height (cms)		B. Weight (kgs)		C. Life Style Details		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>										
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>										
	i Is your occupation associated with any specific hazard (e.g. chemical factory, mines, explosives, radiation, corrosive chemicals, working at heights, diving etc.)?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ii Are you employed in the armed, paramilitary or police forces?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	iii Do you take part in activities or have hobbies that could be dangerous in any way?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	iv Do you consume or have ever consumed Tobacco, Alcohol or any Narcotic? (If yes, specify the quantity per day & no. of years since consuming on a separate sheet)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	D. Health Details				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i Do you have any congenital defect/ abnormality?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ii Do you have any physical deformity/handicap or use any mechanical/ physical assistance for mobility?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	iii In the last 5 years, have you for any illness or injury been admitted to hospital for 2 days or more or received medical treatment for continuous 7 days or more or undergone any surgical procedures or diagnostic tests (including mammogram and PAP smear) or medical examinations with abnormal results or have you been advised to undergo any test or investigation or surgery?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	iv Are you aware of or have you ever been treated or hospitalized for Cancer, Tumour, Cyst or any other growth?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	v Any Ailment/ Injury/ Accident requiring Treatment/ Medication for more than a week?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	vi In the last 2 years, have you availed leave on medical grounds for over 2 consecutive days?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	E. Have you ever suffered or are suffering from any of the following				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(a) Diabetes/ High Blood Sugar				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(b) High/Low BP (Blood Pressure)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(c) Disorders of Eye, Ear, Nose, Throat including defective sight or speech or hearing or discharge from ears?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(d) Change in weight of 10 kgs or more in the last six months?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(e) Symptoms/ ailments relating to Brain, Mental/ Psychiatric ailment, Parkinsonism, Multiple Sclerosis, Nervous system, Stroke, Paralysis, or Epilepsy				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(f) Asthma, Bronchitis, Blood Spitting, Tuberculosis or other Respiratory disorders				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(g) Anemia, Blood or Blood related disorders				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(h) Musculoskeletal disorders such as Arthritis, recurrent back pain, slipped disc or any other disorder of Spine, Joints or Limbs or Leprosy				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(i) Were you or your spouse ever tested for Hepatitis B or C, HIV/AIDS or any other Sexually Transmitted Disease?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(j) Chest pain, Palpitation, Rheumatic fever, heart murmur, heart attack, shortness of breath or any other heart related disorder				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(k) Symptoms/ ailments relating to kidney, bladder, prostate, testes, scrotum or any other disorders of urinary system				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(l) Gastritis, Stomach or Duodenal Ulcer, Hernia, Liver disease, Jaundice, Hepatitis, Fistula, Piles or any other disease or disorders of the Gastro-Intestinal System.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(m) Thyroid disorder or any other disease or disorder of the Endocrine system				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(n) Any other illness or impairment not mentioned above				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	F. Female lives only (Strike off if not applicable)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i Have you ever suffered /are you suffering from Gynecological problems?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ii Are you Pregnant at present? If yes, mention the duration in weeks				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	iii Any complications, miscarriage, medical termination of pregnancy or Caesarian?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	iv Have you ever undergone any investigation or treatment or received medical advice or consulted a physician for:				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	a. Any disease or disorder of the Cervix, Uterus, Ovary (ies) or Vagina, abnormal bleeding, Cancer or abnormal growth?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Any disease or disorder of the Breast(s) such as Breast Lump/cyst, Fibrocystic disease, Nipple changes or discharge, cancer or growth?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. IF ANSWER TO ANY OF THE QUESTIONS FROM 3C. TO 3F. IS YES, PLEASE PROVIDE FOLLOWING DETAILS ON A SEPARATE SHEET:

- (i) Name of Life to be insured
- (ii) Name & Address of treating doctor
- (iii) Nature of Ailment/ Exact Diagnosis
- (iv) First Date of Diagnosis
- (v) Details of Symptoms (Onset, Intensity & Duration)
- (vi) List of prescriptions or medicines
- (vii) Further planned consultation (if any)

5. HAS THE LIFE ASSURED CHANGED HIS/HER OCCUPATION/ RESIDENCE/ AVOCATION FROM THE DATE OF POLICY ISSUANCE/ LAST REVIVAL?

If yes, is the occupation (e.g. chemical factory, mines, explosives, radiation, corrosive chemicals, etc.)/ avocation (e.g. aviation, other than as a fare paying passenger, diving, mountaineering, any form of racing, etc.) associated with any specific hazard/ risk.

Please give details:

6. WHAT IS THE STATUS OF OTHER PROPOSAL/ REVIVAL APPLICATION (IF ANY), FOR AN INSURANCE POLICY (IES) ON THE LIFE OF THE LIFE ASSURED WITH ICICI PRUDENTIAL OR ANY OTHER INSURANCE COMPANY, AFTER THE DATE OF PROPOSAL OF THIS POLICY/ LAST REVIVAL?

Policy or Proposal No.	Company Name	Year of Issue / Application	Medical Policy		Annual Premium (Rs.)	Basic Sum Assured (Rs.)	Basic Plan – Decision (Std. / With Extra Premium / Postponed/ Declined / Not Completed)	Mention names of Riders and Decision (Std. / With Extra Premium / Postponed/ Declined / Not Completed)	In Force/ Lapsed (Mention year of Lapse / Revival Applied for)
			Yes	No					

• Please attach a separate sheet in case the space is inadequate

DECLARATION AND AUTHORISATION

I/We declare that I/We have answered the questions in the proposal form after being explained by the advisor of the ICICI Prudential Life Insurance Company Limited, (hereinafter referred to as 'the Company') and have fully understood the nature of the questions including health related questions 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 proposal form and the information given to the Medical Examiner of the company as to the state of health and habits of the life/lives to be 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 answer and statements on this application. I/We undertake to notify the company of any change in the state of health of the life / lives to be assured or as to his/their occupation(s) subsequent to the signing of this proposal and before the acceptance of the risk by the company. I/We also understand that in case of any mis-statement or suppression of material information or where the Company is not notified of the change in health, the Company has the right to repudiate the claim under the policy. The policy shall become void where it is found that the policy was issued on the basis of fake/tampered documents and/ or proofs. I/We also certify that I/We have read and understood the Benefits Illustrations as published by the company that were handed over to me/us along with this proposal form. 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 to the applicable laws. I/We confirm that all premiums will be paid from bonafide sources.

I/we agree that we will not use fraudulent means for making claims. I/we also agree that if we do it, the company will terminate the contract.

I/We hereby authorize ICICI Prudential Life Insurance Co. Ltd. to conduct screening/confirmation/reconfirmation of overall status of the life /lives to be insured including the health status through medical examinations which may include Laboratory tests, Cardiology, 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. I/We am/ are aware that this test is only for screening purpose and not confirmatory for HIV/AIDS.

The company reserves the right to accept, decline or offer alternate terms on my proposal for life Insurance.

In order to enable the company to assess the risk under this proposal 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 organization or Life Insurance Association's medical register to release to the Company and the Company to release to 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.

This proposal form shall be a part of the life insurance policy contract, in case of its acceptance by the Company

Primary Life Spouse Child 1 Child 2 Child 3 Proposer (If different from lives to be insured)

Signature/thumb impression of the **Life / Lives to be insured** (Not required for Life/ Lives Assured below 18 yrs of age)

Signature of Advisor _____ (If thumb impression is provided by life to be assured then it has to be witnessed by the advisor)

Date DD/MM/YYYY Place

ACKNOWLEDGEMENT SLIP

This is to acknowledgement the receipt of Personal Health Declaration Form

Policy Number:

Date: DD/MM/YYYY

Received By



DECLARATION AND AUTHORISATION

Section 41 of the Insurance Act 1938 (4 of 1938): (1) 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 or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer: Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer. (2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to five hundred rupees.

Section 45: No policy of life insurance effected before the commencement of this Act shall after the expiry of two years from the date of commencement of this 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 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 policy-holder and that the policy-holder knew at the time of making it 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.

DECLARATION

Applicable when the Proposer is illiterate or suffering from disability due to which writing is restricted or where the Proposer has signed in vernacular language. (Note: The below must be witnessed by some one other than the advisor/employee of the company)

I certify that the product applied for by me and the contents of the proposal form have been clearly explained to me and I have fully understood them.

I further certify that the replies in the proposal form have been recorded as per the information provided by me.

I (Name of Witness) _____ Son / Daughter of _____ adult and inhabitant of _____ residing at _____ and _____ (Relation with Proposer)

do hereby state that I have read out and explained the contents of the proposal form and all other documents incidental to availing the Insurance Policy from ICICI Prudential Life Insurance Company Limited to Mr./Mrs./Ms. _____ and he/she /they have understood the same and do hereby agree to abide by all the terms and conditions of the policy and the clauses of the same. I declare that whatever I have stated herein above is true and correct to the best of my knowledge and belief. Solemnly affirmed at _____ on this.

(Signature of Witness)

(Signature/ thumb impression proposer)

Date DD/MM/YYYY

Place

FOR OFFICE USE ONLY:

ER Request submitted by C S CR CS

Spaarc Call ID

Date: DD/MM/YYYY

Scanning Cabinet

Received By

Remarks

STAMP
&
TIME

Kindly call our Customer Service Number 1860 266 7766 (Local charges apply)
Call Center timings: 9.00 A.M. to 9.00 P.M. Monday to Saturday (except national holidays)



Communication Address

ICICI Prudential Life Insurance Company Ltd., Vinod Silk Mills Compound, Chakravarthy Ashok Nagar, Ashok Road, Kandivali (E), Mumbai 400 101.