12M PERSONAL HEALTH DECLARATION FORM

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Received By

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L	I E I	I S U	R A	N C	E	

Guidelines: ✓ This form should contain the details of Life Assured. ✓ This format should be used for revival/ Increase in SA/ Rider Addition/ Increase in SA/ Rider Additin SA/ Rider Addition/ Increase in SA/ Rider Additio		Barcode						
 Insurance is a contract made in utmost good 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/Increase in SA/Addition of Rider/Increase in Rider SA/Top Up will be effective from the final underwriting decision date or the date of receipt of full premium amo or the date of receipt of consent for the revised premium, whichever is later. 								
 Validity of this PHD is 6 months. In case any health riders are attached to the poli Increase in Sum Assured / Addition of Rider is product specific. Please refer to the 		onths.						
Policy No./ Nos:			Da	ate: DDDMM	YY	ΥY		
Name of the Life Assured:				rname				
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:								
I, herewith, apply for:								
Revival of the Policy Increase my Life/ Rider Sum Assured from Rs.	to Rs. (a	allowed for select pla	ns)					
Addition of Rider (allowed for select plans)	,							
Please add the following Riders to my policy: Rider Name	Term (years)	Sum Assure	1 (Rs.)	Premium (Rs.)			
			- ()					
Please provide the following information:					VEO			
1. Height of Life Assured cms. Weight of Life As	sured kgs.				YES	NO		
2. Is the Life Assured in good health? If No, please give details:								
3. Health Questions:								
 a) Do you have any physical deformity/ handicap/ congenital defect/ abnormal by Have you ever consulted any doctor or are you currently undergoing and the second se		ults of any tests or inv	estigations or l	have you ever been				
advised to undergo any tests, investigations or surgery or been hospita	alized for general check up, Observat	ion, Treatment or Surg	ery?					
c) Are you aware of or have you ever been treated or hospitalized for Can investigation or treatment?	icer, Tumour, Cyst or any other grown	th or referred to an Un	cologist or Can	cer hospital for any				
d) Did you have any Ailment/ Injury/ Accident requiring Treatment/ Medic								
 e) Have you ever availed leave on medical grounds in the last two years? f) Has the Life Assured ("you") suffered or is suffering from any of the following th								
(i) Diabetes/ High Blood Sugar/ High/Low BP (Blood Pressure)								
 (ii) Disorders of Eye, Ear, Nose, Throat including defective sight or sp (iii) Ailments relating to Liver, Reproductive System 	beech or hearing and discharge from	ears						
(iv) Loss of Weight of 10 kgs or more in the last six months				F 11				
 (v) Symptoms/ ailments relating to Brain, Mental / Psychiatric ailmen (vi) Asthma, Bronchitis, Blood Spitting, Tuberculosis or other Respirat 		Nervous system, Stro	ke, Paralysis or	Epilepsy				
(vii) Anemia, Blood or Blood related disorders, musculoskeletal disord	ers such as Arthritis, recurrent back	pain, slipped disc or a	ny other disord	ler of Spine, Joints				
or Limbs or Leprosy (viii) Were you or your spouse ever tested for Hepatitis B or C, HIV/AIDS or any other Sexually Transmitted Disease?								
(ix) Chest pain, Palpitation, Rheumatic fever, heart murmur, heart attack, shortness of breath or any other heart related disorder								
 (x) Symptoms/ ailments relating to kidney, prostate, hydrocele, urinary system (xi) Gastritis, Stomach or Duodenal Ulcer, Hernia, Liver disease, Jaundice, Hepatitis, Fistula, Ries or any other disease or disorders of the Gastro-Intestinal System. 								
(xii) Thyroid disorder or any other disease or disorder of the Endocrine system, High Cholesterol/ Hyperlipidemia								
(xiii) Have you undergone/ have been recommended to under go any of the following- Angioplasty, Bypass Surgery, Brain surgery, Heart valve surgery, Aorta surgery or organ transplant or any other major Surgery or Treatment								
g) Any other illness or impairment not mentioned above								
4. Have you ever been or currently being investigated, charge sheeted, prosecuted or convicted or acquittal or having pending charges in respect of any criminal/civil offences in any court of law in India or abroad?								
If Yes, give details.								
 Following Questions need to be answered if the Life Assured ("you") is Have you ever suffered / Are you suffering from Gynaecological proble 								
b) i) Are you pregnant at present? If Yes, duration in weeks								
 ii) Any complications, miscarriage, medical Termination of Pregnancy or Caesarian, if applicable c) Have you ever undergone any investigation or treatment or received medical advice or consulted a physician for 								
 Any disease or disorder if the cervix, uterus, ovary(ies) or vagina, Any disease of disorder if the heart (t) and heart the second second			4.0					
 ii) Any disease or disorder of the breast(s) such breast lump, cyst, fi iii) Have you undergone any mammogram or Papsmear? 	brocystic disease, hipple change or o	uscharge, cancer or g	rowth?					
ACKNOWLEDGEMENT SLIP			[
This is to acknowledge the receipt of application for Personal Health Declaration								
Policy No./ Nos:				STAMP &				
D D M Y Y Y				TIME				

wring of Ireatmo										
	Dates:									
	g leave(ailment, d	isease, injury	/).							
oes the Life Ass	ured consume /	has consum	ed any of t	he follow	ving?					
Substance Co	nsumed	YES	NO		-	Con	sumed as		Quantity / Day	For No. of Years
Торассо				Cigar	r/Cigarett	e/Beedi/Gutkha				
Alcohol				Beer	/Wine/Ha	rd Liquor				
Any Narcotic										
as the Life Assu	red changed his/	/her occupat	tion/ reside	nce/ avo	cation fro	om the date of Polic	cy Issuance/ last r	evival?		YES NO
								J. aviation, other than	as a fare paying passeng	er,
ving, mountainee	ering, any form of	racing, etc.) a	associated	with any	specific h	azard/ risk. Please ç	give details:			
/hat is the statu	e of other propos	al/rovival a	nnligation	(if any)	for an ine	urance policy (ies)	on the life of the l	ife Assured with ICI	CI Prudential or any oth	or
	ny, after the date					urance policy (les)		Life Assured with IGI	or riducitial of any ou	161
Policy or	Company	Year of	· · ·	Medica		Annual	Basic Sum	Basic Plan -	Mention names	In Force/
Proposal No.	Name	applica		Policy		Premium (Rs.)	Assured (Rs.)	decision (Std./	of Riders and	Lapsed
•							A330100 (113.)	With Extra/	decision (Std./ With	h (Mention year
								Postponed/ Declined/ Not	Extra/ Postponed/	of Lapse/
									Declined/ Not	Revival
				Yes	No			Completed)	Completed)	Applied For)
	arate sheet in cas									
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e declare that I/We is to all the questic e not withheld any rance Company Li ipation subsequen hereby authorize th may include Lat /2 test by ELISA m nate terms on this der to enable the C ical source/any liffu life insurance com ay be collected an da s stated in the	have fully understo ns in the form and the material information mited which in any t to the signing of the ICICI Prudential Life oratory tests, Card ethod. I am/ We are application. company to assess the and non-life insuran pany/or Life Insuran dused by ICICI Pruc yuidelines and appli	od the questic ne information n or suppresse is form and bel linsurance Co iac, Radiologi e aware that th he risk under th nce company/ ice Associatio Jential Life Insi cable as per th	ons in the form given to the d any materi the answer fore the acce . Ltd. to cond cal investiga his test is onl his applicatio (or organisat n or medical urance Co. L1 e product ty	Medical E ial fact. I/ V s and stat ptance of duct scree tions and y for scree on and any ion or Life register, s d. for the pe, shall b	xaminer of We have m tements in the risk by ening/ confi other medi ening purpor time there Insurance <i>i</i> uch details purpose of e applicab	the Company as to the iade no statement to this form. I/We under the company for revive irmation/ reconfirmatic ical tests including blo base and not confirmator after, I/We hereby, aut Association's medical and provide the recorn providing/ offering me le after revival of the p	e state of health and he he Insurance Advisor, rtake to notify the Co al / Addition of Rider/ i on of overall status of ood tests to detect be ory for HIV-AIDS. I/W thorize the past and pr register to release to ds of employment/bu s/ us promotional mat olicy. I/We also unde	abits of the Life Assured , Medical Examiner, or a impany of any change in increase in Life/ Health S of the Life Assured incluce acterial/viral/fungal infec //e understood that the C resent employers(s)/ but the Company and the Co isiness or other details a terial relating to any proc restand that the terms ar hinsurance policy contra	are true and complete in ev ny other person associated in the state of health of the um Assured ling the health status throu tions. I/We hereby give m ompany reserves the right siness associates/ medical ompany to release to any m s may be considered releva lucts and services. I/ We he d conditions including the	ery respect and that I/M with ICICI Prudential Li Life Assured or as to h gh medical examination y/our consent to underg to accept, decline or off practitioner/ hospital ar edical source/ any life ar nt. Information about m reby agree that a waith premium and the benefi
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Communication Address ICICI Prudential Life Insurance Co. Ltd., Unit No. 1A & 2A, Raheja Tipco Plaza, Rani Sati Marg, Malad (East), Mumbai 400097.

C0\	/ID-19 DECLAR	ATION FORM						
 ✓ Insufact ✓ Valie 	form should contain the details of Life rance is a contract made in utmost g s, in response to the questions in this f dity of this declaration is 30 days from	ood faith, trusting the proposer and the life form	Barcode					
Policy	No./ Nos:				Date: D D	MMYY	YY	
Name	of the Life Assured:	Mrs. First Name			Surname			
	of the proposer: Mr./Ms./I	Mrs. First Name			Surname			
Contac	t numbers:	Residence S	TD Office E	xt. ISD		Mobile		
E-mail	ID:							
For life	policies, please provide details o	of primary life assured only. For heal	h policies, please provide details of all lives c	overed.				
Please	provide the following informa	tion:		Drimony				
	Questions			Primary Life Assured Yes No	Spouse Chi Yes No Yes	ld 1 Child 2 No Yes No	Child 3 Yes No	
1	Have you ever been tested positiv If your answer to the above question is y							
1.1	Are you fully recovered? If your answer to the above question is y	es, please answer the next question.						
1.2a 1.2b	Date of diagnosis Date of recovery							
1.3	Were you hospitalized for COVID-	 19 treatment?						
2			plated with symptoms on medical advice?					
2	(excluding mandatory governmen		una comiting diawhan difficulty in					
3	breathing, loss of smell and taste		OVID-19) and advised to do a COVID test or					
4	Do you work in an occupation like doctors, surgeons, therapists, nu hospitals/ clinics having novel co	rses, pathologist, paramedics, pharmac	clude (general practitioners, doctors, hospital ist, ward helpers, individuals working in d) where you have a higher risk to get in					
5	Are your currently residing outsid							
5.a	Name of country							
5.b	City							
5.c	Date of travel DD/MM/YYYY	_						
5.d 5.1	Intended duration (in Months) Have you travelled abroad in past	t 14 days						
Coun	try 1	Country 2	Country 3					
		5.1a Name of country						
	City	5.1b City						
		5.1d Date DepartedDD/MM/YYYY						
	Do you intend to travel abroad in							
Coun	try 1 Name of country	Country 2 5.2a Name of country	Country 3 5.2a Name of country					
		5.2b City						
		5.2c Date Arrived DD/MM/YYYY						
5.2d (in M	Intended duration <u>DD/MM/YYYY</u> onths)	5.2d Intended duration DD/MM/YYYY (in Months)	5.2d Intended duration DD/MM/YYYY (in Months)					
6	Have you been vaccinated for CO	VID19?	_					
6a								
6b							_	
6.1	Have you been vaccinated with S							
6.1a 6.2b								
6.20	Have you experienced any advers		_					
	(If yes)							
		ment taken for the same and date of com	plete recovery					

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 hereafter, I/We hereaft

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)

Signature of Witness/ person filling the form

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



Place: