## **COVID-19 DECLARATION FORM**



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.  Policy No./ Nos:						Barcode  Date: DD MM MYYYYY				
Mr./Ms./Mrs. First Name  Name of the proposer: (If different from the Life Assured)  Mr./Ms./Mrs. First Name						Surname				
	t numbers:	Ext.								
E-mail	ID:									
For life	policies, please provide details o	of primary life assured only. For health	policies, please provide details of all live	es covere	ed.					
Please	provide the following informa	tion:								
Sr. No.	Questions				Primary Life Assured	Spouse	Child 1	Child 2	Child 3	
1	Have you ever been tested positive of your answer to the above question is you				Yes No	Yes No	Yes No	Yes No	Yes No	
1.1	Are you fully recovered?									
1.2a	If your answer to the above question is yes, please answer the next question.  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 a (excluding mandatory governmen		ated with symptoms on medical advice?							
3	breathing, loss of smell and taste	persistent cough, fever, sore throat, naus any other symptoms of coronavirus (CO en in contact with an individual suspecte	VID-19) and advised to do a COVID test or							
4	Do you work in an occupation like doctors, surgeons, therapists, nur hospitals/ clinics having novel co	e health care worker/Corona warrior Inc rses, pathologist, paramedics, pharmaci	lude (general practitioners, doctors, hospita st, ward helpers, individuals working in ) where you have a higher risk to get in	al						
5	Are your currently residing outsid	le of India								
5.a	Name of country									
5.b	City									
5.c	Date of travelDD/MM/YYYY	_								
5.d	Intended duration (in Months)									
<b>5.1</b> Count	Have you travelled abroad in past	: <b>14 days</b> Country 2	Country 3							
		5.1a Name of country								
		5.1b City								
5.1c	Date ArrivedDD/MM/YYYY	5.1c Date ArrivedDD/MM/YYYY	5.1c Date ArrivedDD/MM/YYYY							
5.1d	Date DepartedDD/MM/YYYY	5.1d Date DepartedDD/MM/YYYY	5.1d Date DepartedDD/MM/YYYY							
5.2	Do you intend to travel abroad in	next 3 month								
Count		Country 2 5.2a Name of country	Country 3 5.2a Name of country							
		5.2b City								
		5.2c Date ArrivedDD/MM/YYYY								
5.2d		5.2d Intended duration DD/MM/YYYY (in Months)								
6	Have you been vaccinated for CO (If answered as "Yes")									
6a	(If answered as "Yes")  Date of First dose									
6b				-						
6.1	Have you been vaccinated with Second dose									
6.1a	Date of Second dose		_							
6.2b										
6.2	Have you experienced any advers	•								
		ment taken for the same and date of compl	ete recovery							

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## **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. If 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 ICCIC 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 de offering me/ us promotional material relating to any products and services. I/ We he that the terms and conditions including the premium and the benefits payable under	reby agree that a waiting period as stated in the guidelines and applicable as per t	the product type, shall be applicable after revival of the policy. I/ We also understand
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 disab statement below must be witnessed by someone other than the advis I/ We verify that the contents of the this form have been read over an	ility due to which his/ her capacity for writing is restricted or wh sor/ employee of the Company.	, , ,
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)	Date: DDDMMMYYYYY