

Health Certificate

Application for: Reinstatement of lapsed policy Surrender Reversal request Addition of Riders

Changes in personal details: Increase in Sum assured/ Other insurance/ Habits/ Occupation

PAN Number of Policyholder (attach copy of PAN Card) (Required if amount remitted is greater than ₹50000/-)

Personal details: Section A

Policy No./Nos:

PARTICULARS		LIFE ASSURED		POLICYHOLDER (If other than Life Assured)		
1. Title		<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. Others _____	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. Others _____			
2. Name	First	<input type="text"/>		<input type="text"/>		
	Middle	<input type="text"/>		<input type="text"/>		
	Last	<input type="text"/>		<input type="text"/>		
3. Gender & DOB		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="text"/> DD/MM/YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="text"/> DD/MM/YYYY			
4. Marital Status		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower			
5. Current Address (Pls. provide proof of your current address if it is different from address registered with us)		Add1 : _____ Add2 : _____ Add3 : _____ Add4 : _____ Landmark : _____ City : _____ State : _____ Country : _____ Pincode : _____	Add1 : _____ Add2 : _____ Add3 : _____ Add4 : _____ Landmark : _____ City : _____ State : _____ Country : _____ Pincode : _____			
6. Telephone & E-mail Details (shall be updated in our records, if different from existing)	Residence	<input type="text"/>		<input type="text"/>		
	Office	<input type="text"/>		<input type="text"/>		
	Mobile	<input type="text"/>		<input type="text"/>		
	E-mail	<input type="text"/>		<input type="text"/>		

Personal details: Section B

						Insured	Policyholder
1. a) Height						___ CM / ___ feet	___ CM / ___ feet
b) Weight kg/lb						___ kg / ___ lbs	___ kg / ___ lbs
c) Has there been any change in your weight in the last 12 months? If 'Yes', please state amount changed and cause if known. Yes / No: _____						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you smoke or otherwise use tobacco products or have done so in the last 12 months?						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Substance Consumed	Yes	No	Consumed As	Quantity/ day	For No. of years		
Tobacco							
Alcohol							
Narcotics							
3. Are you employed in the Armed Forces, Paramilitary or Police Forces or Fire Brigade? If yes, please provide details in questionnaire (* Please attach relevant occupation questionnaire to reinstate your policy) _____						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you now a member of any military force, engaged or are considering engaging in any hazardous sports or events (e.g. motor racing, climbing, scuba diving Insured/Policyholder etc.) or flying in any aerial device other than as a fare paying passenger on a regularly scheduled airline or travel overseas other than for vacation or holiday? (* Please attach relevant Hobbies questionnaire to reinstate your policy)						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you changed your occupation from the date of policy issuance /last revival? If yes, please provide details: _____ Occupation (e.g. Chemical factory, Mines, explosives, radiations, corrosive chemicals etc)/ Avocation (e.g. Aviation, other than fare paying passenger, diving, mountaineering, any form of racing etc) associated with any specific hazard/ risk. (* Please attach relevant occupation questionnaire to reinstate your policy)						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you a Politically Exposed Person? If "Yes" then please provide details _____ Definition of PEP: Politically exposed persons are individuals who are or have been entrusted with prominent public functions in a foreign country e.g. Heads of States or of Governments, senior politicians, senior government / judicial / military officers, senior executives of state-owned corporations, important political party officials etc. It should also include persons who are affiliated to a Domestic political party / Central or State Government or any government official not below the rank of an Under-secretary.						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Disclosure: SECTION C

		Insured	Policyholder
1. Have you EVER HAD any of the following?			
a) Stroke, epilepsy, fits recurrent headache, paralysis, faints or any other disease or disorder of the brain, spinal cord or nerves?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Depression, anxiety, schizophrenia or any other mental or nervous disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Diabetes, thyroid disorders or any other hormone disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Ear discharge, impaired sight, hearing, or speech or any other disorder of ear, eye, nose or throat?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Asthma, pneumonia, tuberculosis, emphysema, coughing up blood, persistent cough, or any other disorder of the chest or lungs?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) High blood pressure, palpitations, chest pain, raised cholesterol, heart attack, or any other disorder of the heart or blood vessels?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Hepatitis (including Hepatitis B carrier), liver disorder, gall bladder disorder, ulcer, bleeding from the stomach or bowel, hemorrhoids or any other disorder of the digestive tract?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Kidney or bladder disorder, urine abnormality or genital organ disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Cancer, tumor, cyst or growth of any kind?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Anemia, hemophilia, leukemia or any other blood disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) Back or neck complaint, arthritis, gout, physical disability or other disorder of the bones joints or muscles?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) Any illness that has caused you to be absent from work for a continuous period of 7 days or more?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. a) Have you been infected with HIV (Human Immunodeficiency Virus), been diagnosed as having HIV antibodies or suffered from an AIDS related condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Have you or your spouse received medical advice, testing or treatment in connection with sexually transmitted disease or HIV infection or suffered from prolonged weight loss, diarrhea, enlarged glands or unusual skin lesion or been advised to abstain from donating blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you had any other illness, injury, operation or abnormality not mentioned under any question above which is recurrent or has symptoms persisting for more than 7 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have any symptoms or condition for which you intend to attend a doctor in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the last 5 years, have you attended doctor or any other medical facility for investigation or diagnostic tests (such as blood or urine, X-ray, ultrasound, CT scan, biopsy, ECG, Angioplasty, Bypass Surgery, Brain Surgery, Heart Valve Surgery, Aorta Surgery or Organ Transplant or any treatment for Cancerous growth, of any kind etc.)? If yes, please provide details: _____ (* If any of the above questions is answered as Yes, please specify further below) Reasons of Tests done & Date of Diagnosis: _____ Tests Recommended by consulting doctor: _____ Tests completed & Date of Tests: _____ Current Condition as per Family/ Consulting doctor: _____ *Please attach complete personal reports copy to reinstate your policy (* Applicable for all treatments done in last 5 years)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have either of your natural parents or any siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder or depression, tuberculosis or polycystic kidney or other hereditary disease before the age of 65? If 'Yes', please provide details (type of cancer if applicable): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Female Life Questions: a) Are you now pregnant? If 'yes', please state expected delivery date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD/MM/YYYY b) Have you undergone any gynecological investigations for illness, internal checkups, breast checks such as mammogram or biopsy? c) Have you ever consulted a doctor because of an irregularity at the breast, vagina, uterus, ovary, fallopian tubes, menstruation, complications during pregnancy or child delivery or a sexually transmitted disease? d) Have you suffered from any other disorder of the breast or reproductive organs, abnormal smear test(s) and irregular menses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Medical Declaration: SECTION D: (*The following to be answered if Life Assured has opted for Health Products/ Critical Illness benefits/ surgical benefits)	Insured	Policyholder
1. Do you have any physical defects, impairment, deformities and/or any condition affecting mobility, sight and/or hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past 10 years have you been diagnosed, treated or sought treatment or advice for cancer (including skin cancer or ulcerated moles), tumor or leukemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past 5 years have you had any diagnostic tests e.g. Mammogram, X-ray, ultrasound, CT scan, biopsy, blood or urine test for any lump, cyst, tumor, chronic lesions or growths of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. If "Yes" to question 3, did the results warrant further testing, treatment, referral to another doctor or specialist, follow up with your own doctor or future follow-up recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have 2 or more immediate family members (natural parents & siblings) ever been diagnosed below age 60 with cancer, tumor or leukemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. a) Male Applicant: Has your father been diagnosed with bowel or colon cancer, below age 60? b) Female Applicant: Has your mother been diagnosed with breast cancer, below age 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

IMPORTANT NOTE
In case of policy on the life of Juvenile, where Waiver of Premium Plus rider is attached, it is mandatory to fill the details of policyholder

Declaration And Authorization: You have to disclose in this application ALL material facts which shall form the basis of our contract, otherwise the policy issued may be void or voidable. If you are in doubt whether a fact is material, please disclose it.

Declaration & Authorization: I/We hereby declare and agree that (a) I/We have read the application or the same was interpreted to me/us, and the answers entered in the application are mine/ours; (b) I/We hereby certify, that each of the above answers is full, complete and true and I/We understand that Tata AIA Life Insurance Co. Ltd. (hereafter called "the Company") believing them to be such, will rely and act on them, (c) the policy shall not be considered as reinstated only by reason of any money paid, or settlement made in payment of or on account of any premium, until this application is received by the Company during the life time of the Insured / Policyholder and is approved by an authorized officer of the Company; (d) if my/our application be accepted by the Company, the Incontestability and Suicide Provision thereof shall have effect from the approval date of my/our application. Furthermore, I hereby irrevocably authorize (a) any organization, institution, or individual that has any record of knowledge of my/the Insured's health or medical history or financial history or other personal information; to disclose to the Company such information. This authorization shall bind my/the insured's successors and assigns and remain valid notwithstanding my/the Insured's death or incapacity in so far as legally possible; and (b) the Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and test to underwrite and evaluate my/the Insured's health status in relation to this application and any claim arising there from. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, Acquired Immuno Deficiency Syndrome (AIDS), infection by any Human Immunodeficiency Virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites. I also agree and undertake that a) if there is any material change in my circumstances, including but not limited to, changes in my/insured's health, employment, financial circumstances, arrest or being charged with a criminal offence, non-standard acceptance or rejection of a life insurance application, prior to the acceptance of the Company of this application for insurance, I will immediately notify the Company of such change in writing, and b) the Company will take into account any such change in circumstances in deciding whether to reject or accept this application, and c) failure to notify the Company in this manner shall, at the Company's discretion, render this policy void and no benefit shall be payable under this policy.

INSURANCE ACT 1938, Section 41 -Prohibition of Rebates: 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 a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer. Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to five hundred rupees.

INSURANCE ACT 1938, Section 45: No policy of life insurance effected before the commencement of this Act shall after expiry of two years from the date of commencement of the Insurance 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 (application) 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 Policyholder and that the Policyholder knew at the time of making, 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 (application).

Validity: 90 days from date of signing the health certificate

Signature/Thumb Impression of Insured Signature/Thumb Impression of Policyholder Date of sign on HC Signature of Agent

IN CASE ANSWERS TO THE QUESTIONS ARE FILLED IN BY A PERSON OTHER THAN THE POLICYHOLDER OR WHERE THE ANSWERS / SIGNATURE OF THE POLICYHOLDER / LIFE ASSURED ARE IN VERNACULAR

The thumb impression or signature of the Policyholder /Life Assured should be attested by a person of standing whose identity can easily be established and this declaration should be made by him/her.

I _____ (name) holding _____ (Identity Card type) _____ (Identity Card no.) hereby declare that I have explained the contents of this form to the Policyholder/Life Assured in _____ language and that I have read out to the Policyholder/Life Assured the answers to the questions dictated by the Policyholder/Life Assured. The information/answers filled in this form are exact replication of the information/answers provided to me by the Policyholder/Life Assured and that the Policyholder /Life Assured has affixed his/her signature/thumb impression on this form after fully understanding the contents thereof

Witness Details: Name: _____ Signature: _____ ID Proof Type: _____ ID Proof Number: _____

For more details please contact our insurance advisor or visit our Tata AIA Life's nearest branch office or call our helpline numbers 1800 267 9966 (toll free) or 1860 266 9966 (local charges apply) or email us at customercare@tataaia.com or SMS "LIFE" to 58888 or visit us at www.tataaia.com.

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