TATA AIA LIFE

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		☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. Others ______	☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. Others ______
2. Name	First		
	Middle		
	Last		
3. Gender		☐ Male ☐ Female	☐ Male ☐ Female
4. Marital Status		☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower	☐ Single ☐ Married ☐ Divorced ☐ 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		
	Office		
	Mobile		
	E-mail		

Personal details: Section B

Question	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	☐ Yes ☐ No
2. Do you smoke or otherwise use tobacco products or have done so in the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No

Substance Consumed	Yes	No	Consumed As	Quantity/ day	For No. of years
Tobacco					
Alcohol					
Narcotics					

Question	Insured	Policyholder
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)______	☐ Yes ☐ No	☐ Yes ☐ 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)	☐ Yes ☐ No	☐ Yes ☐ 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)	☐ Yes ☐ No	☐ Yes ☐ No
6. Are you a Politically Exposed Person? If "Yes" then please provide details ______ **Definition of PEP:" PEP are individuals who are or have been entrusted with prominent public functions, domestically/ in an international organisation/ in a foreign country. This would include individuals who have or have had positions of Heads of State or of government, senior politicians, senior government, judicial or military officials, senior executives of state owned corporations, important political party officials". "Close relations of PEP: Family members are individuals who are related to a PEP either directly (consanguinity) or through marriage or similar (civil) forms of partnership. Close associates are individuals closely connected to a PEP, either socially or professionally"	☐ Yes ☐ No	☐ Yes ☐ No

Medical Disclosure: SECTION C

Question	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?	☐ Yes ☐ No	☐ Yes ☐ No
b) Depression, anxiety, schizophrenia or any other mental or nervous disorder?	☐ Yes ☐ No	☐ Yes ☐ No
c) Diabetes, thyroid disorders or any other hormone disorder?	☐ Yes ☐ No	☐ Yes ☐ No
d) Ear discharge, impaired sight, hearing, or speech or any other disorder of ear, eye, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No
e) Asthma, pneumonia, tuberculosis, emphysema, coughing up blood, persistent cough, or any other disorder of the chest or lungs?	☐ Yes ☐ No	☐ Yes ☐ No
f) High blood pressure, palpitations, chest pain, raised cholesterol, heart attack, or any other disorder of the heart or blood vessels?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
h) Kidney or bladder disorder, urine abnormality or genital organ disorder?	☐ Yes ☐ No	☐ Yes ☐ No
i) Cancer, tumor, cyst or growth of any kind?	☐ Yes ☐ No	☐ Yes ☐ No
j) Anemia, hemophilia, leukemia or any other blood disorder?	☐ Yes ☐ No	☐ Yes ☐ No
k) Back or neck complaint, arthritis, gout, physical disability or other disorder of the bones joints or muscles?	☐ Yes ☐ No	☐ Yes ☐ No
l) Any illness that has caused you to be absent from work for a continuous period of 7 days or more?	☐ Yes ☐ No	☐ Yes ☐ No

Question	Insured	Policyholder
2. a) Have you been infected with HIV (Human Immunodeficiency Virus), been diagnosed as having HIV antibodies or suffered from an AIDS related condition?	Yes No	Yes 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?	Yes No	Yes 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?	Yes No	Yes No
4. Do you have any symptoms or condition for which you intend to attend a doctor in the future?	Yes No	Yes 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)	Yes No	Yes 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): ______	Yes No	Yes No
7. **Female Life Questions:**	Yes No	Yes No
a) Are you now pregnant? If 'yes', please state expected delivery date DD/MM/YYYY		
b) Have you undergone any gynecological investigations for illness, internal checkups, breast checks such as mammogram or biopsy?	Yes No	Yes No
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?	Yes No	Yes No
d) Have you suffered from any other disorder of the breast or reproductive organs, abnormal smear test(s) and irregular menses?	Yes No	Yes No

Additional Medical Declaration: SECTION D: (*The following to be answered if Life Assured has opted for Health Products/ Critical Illness benefit)	Insured	Policyholder
1. Do you have any physical defects, impairment, deformities and/or any condition affecting mobility, sight and/or hearing?	Yes No	Yes 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?	Yes No	Yes 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?	Yes No	Yes 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?	Yes No	Yes No
5. Have 2 or more immediate family members (natural parents & siblings) ever been diagnosed below age 60 with cancer, tumor or leukemia?	Yes No	Yes No
6. a) Male Applicant: Has your father been diagnosed with bowel or colon cancer, below age 60?	Yes No	Yes No
b) Female Applicant: Has your mother been diagnosed with breast cancer, below age 60?	Yes No	Yes No

IMPORTANT NOTE: In case of policy on the life of Juvenile, where Payor Benefit / 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. 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' 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

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

IN CASE ANSWERS TO THE QUESTIONS ARE FILLED IN BY A PERSON OTHER THAN THE PROPOSER OR WHERE THE ANSWERS / SIGNATURE OF THE POLICYHOLDER / LIFE ASSURED ARE IN VERNACULAR. Note: The below must be witnessed by someone other than advisor/ employee of the company.

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 the proposal form to the Policyholder/Life Assured in ______ language and that I have read out to the Policyholder/LifeAssured the answers to the questions dictated by the Policyholder/Life Assured. The information/answers filled in the proposal 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 the proposal form after fully understanding the contents thereof.

______ Signature/Thumb Impression of Policyholder | ______ Signature/Thumb Impression of Life Assured | ______ Signature of the Person making the Declaration

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