12M PERSONAL HEALTH DECLARATION FORM

ICICI PRUDENTIAL LIFE INSURANCE

Barcode

Guidelines:
- ✓ This form should contain the details of Life Assured.
- ✓ This format should be used for revival/ Increase in SA/ Rider Addition/ Increase in Rider SA/ Top Up Requests for a Life policy.
- ✓ 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 amount by the company 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 policy, the validity of this PHD would be 3 months.
- ✓ Increase in Sum Assured / Addition of Rider is product specific. Please refer to the Policy Document for details.

Policy No./ Nos: ______ ______ ______ **Date:** D D M M Y Y Y Y

Name of the Life Assured: ______
Mr./Ms./Mrs. First Name Surname

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.__________________ (allowed for select plans)

☐ Addition of Rider (allowed for select plans)

Please add the following Riders to my policy:

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

Please provide the following information:

YES NO

1. **Height of Life Assured __________________ cms. Weight of Life Assured _______________ kgs.**
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/ abnormality? ☐ ☐
   - **b)** Have you ever consulted any doctor or are you currently undergoing any tests, investigations, awaiting results of any tests or investigations or have you ever been advised to undergo any tests, investigations or surgery or been hospitalized for general check up, Observation, Treatment or Surgery? ☐ ☐
   - **c)** Are you aware of or have you ever been treated or hospitalized for Cancer, Tumour, Cyst or any other growth or referred to an Oncologist or Cancer hospital for any investigation or treatment? ☐ ☐
   - **d)** Did you have any Ailment/ Injury/ Accident requiring Treatment/ Medication for more than a week? ☐ ☐
   - **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?
     - **(i)** Diabetes/ High Blood Sugar/ High/Low BP (Blood Pressure) ☐ ☐
     - **(ii)** Disorders of Eye, Ear, Nose, Throat including defective sight or speech or hearing and discharge from ears ☐ ☐
     - **(iii)** Ailments relating to Liver, Reproductive System ☐ ☐
     - **(iv)** Loss of Weight of 10 kgs or more in the last six months ☐ ☐
     - **(v)** Symptoms/ ailments relating to Brain, Mental / Psychiatric ailment, Parkinsonism, Multiple Sclerosis, Nervous system, Stroke, Paralysis or Epilepsy ☐ ☐
     - **(vi)** Asthma, Bronchitis, Blood Spitting, Tuberculosis or other Respiratory disorders ☐ ☐
     - **(vii)** Anemia, Blood or Blood related disorders, musculoskeletal disorders such as Arthritis, recurrent back pain, slipped disc or any other disorder 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, Piles 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.____
5. **Following Questions need to be answered if the Life Assured ("you") is a Female:**
   - **a)** Have you ever suffered / Are you suffering from Gynaecological problems ? ☐ ☐
   - **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
     - **i)** Any disease or disorder if the cervix, uterus, ovary(ies) or vagina, abnormal bleeding, cancer or growth? ☐ ☐
     - **ii)** Any disease or disorder of the breast(s) such breast lump, cyst, fibrocystic disease, nipple change or discharge, cancer or growth? ☐ ☐
     - **iii)** Have you undergone any mammogram or Papsmear? ☐ ☐

ACKNOWLEDGEMENT SLIP

This is to acknowledge the receipt of application for Personal Health Declaration

Policy No./ Nos: ______ ______ ______

Date D D M M Y Y Y Y

Received By ______

STAMP & TIME

5. If answer to the question No.3 or 4 is 'Yes', please give the following details:

Nature of Ailment / test: _____

Date of diagnosis / test: _____

Period of Treatment / findings: _____

Name of the Doctor / Hospital: _____

Period of Leave & Dates: _____

Reason for availing leave(ailment, disease, injury):

6. Does the Life Assured consume / has consumed any of the following?

Substance Consumed	YES	NO	Consumed as	Quantity / Day	For No. of Years
Tobacco			Cigar/Cigarette/Beedi/Gutkha		
Alcohol			Beer/Wine/Hard Liquor		
Any Narcotic					

7. Has the Life Assured changed his/her occupation/ residence/ avocation from the date of Policy Issuance/ last revival? **YES** ☐ **NO** ☐

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:

_____

8. 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/ Postponed/ Declined/ Not Completed)	Mention names of Riders and decision (Std./ With Extra/ 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 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 state of health 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 state of health 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/ Health 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 health 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 details as may be considered relevant. Information about me/ us may be collected and used by ICICI Prudential Life Insurance Co. Ltd. for the purpose of providing/ offering me/ us promotional material relating to any products and services. I/ We hereby agree that a waiting period as stated in the guidelines and applicable as per the product type, shall be applicable after revival of the policy. 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 with the applicable laws. This form shall be a part of my/ our Life/ Health insurance policy contract.

Signature/ thumb impression of the Life Assured

Signature/ thumb impression of the Policyholder (if different from the Life Assured)

Date: D D M M Y Y Y Y

Place: _____

DECLARATION

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)

Date: D D M M Y Y Y Y

Place: _____

☐ **ER** **Request submitted by** ☐ **C** ☐ **S** ☐ **CR** ☐ **CS**

COMP/DOC/Sep/2021/279/6634

Kindly call our Customer Service Number 1860-266-7766 (local charges apply)
Call Center timings: 10.00 A.M. to 7.00 P.M. Monday to Saturday (except national holidays)

ICICI PRUDENTIAL LIFE INSURANCE

Communication Address

ICICI Prudential Life Insurance Co. Ltd., Unit No. 1A & 2A, Raheja Tipco Plaza, Rani Sati Marg, Malad (East), Mumbai 400097.

COVID-19 DECLARATION FORM

ICICI PRUDENTIAL LIFE INSURANCE

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.

Barcode

Policy No./ Nos: ____________ ____________ ____________ **Date:** D D M M Y Y Y Y

Name of the Life Assured: ____________
Mr./Ms./Mrs. First Name Surname

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: ____________

For life policies, please provide details of primary life assured only. For health policies, please provide details of all lives covered.

Please provide the following information:

Sr. No.	Questions	Primary Life Assured Yes	Primary Life Assured No	Spouse Yes	Spouse No	Child 1 Yes	Child 1 No	Child 2 Yes	Child 2 No	Child 3 Yes	Child 3 No
1	**Have you ever been tested positive for COVID-19?** If your answer to the above question is yes, please answer the next question.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1.1	**Are you fully recovered?** If your answer to the above question is yes, please answer the next question.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1.2a	**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 any of your family member been self-isolated with symptoms on medical advice? (excluding mandatory government orders to remain at home)**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	**In the last 1 month did you have persistent cough, fever, sore throat, nausea, vomiting, diarrhea, difficulty in breathing, loss of smell and taste any other symptoms of coronavirus (COVID-19) and advised to do a COVID test or you/your family member have been in contact with an individual suspected or confirmed to have COVID-19?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	**Do you work in an occupation like health care worker/Corona warrior Include (general practitioners, doctors, hospital doctors, surgeons, therapists, nurses, pathologist, paramedics, pharmacist, ward helpers, individuals working in hospitals/ clinics having novel coronavirus (SARS-CoV-2/COVID-19) Ward) where you have a higher risk to get in close contact with COVID-19 patients or with coronavirus contaminated material?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	**Are your currently residing outside of India**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.a	Name of country ____________										
5.b	City ____________										
5.c	Date of travel DD/MM/YYYY										
5.d	Intended duration (in Months)										
5.1	**Have you travelled abroad in past 14 days**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Country 1	Country 2	Country 3
5.1a Name of country ____________	5.1a Name of country ____________	5.1a Name of country ____________
5.1b City ____________	5.1b City ____________	5.1b City ____________
5.1c Date Arrived DD/MM/YYYY	5.1c Date Arrived DD/MM/YYYY	5.1c Date Arrived DD/MM/YYYY
5.1d Date Departed DD/MM/YYYY	5.1d Date Departed DD/MM/YYYY	5.1d Date Departed DD/MM/YYYY

5.2 Do you intend to travel abroad in next 3 month ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Country 1	Country 2	Country 3
5.2a Name of country ____________	5.2a Name of country ____________	5.2a Name of country ____________
5.2b City ____________	5.2b City ____________	5.2b City ____________
5.2c Date Arrived DD/MM/YYYY	5.2c Date Arrived DD/MM/YYYY	5.2c Date Arrived DD/MM/YYYY
5.2d Intended duration (in Months) DD/MM/YYYY	5.2d Intended duration (in Months) DD/MM/YYYY	5.2d Intended duration (in Months) DD/MM/YYYY

Sr. No.	Questions	Primary Life Assured Yes	Primary Life Assured No	Spouse Yes	Spouse No	Child 1 Yes	Child 1 No	Child 2 Yes	Child 2 No	Child 3 Yes	Child 3 No
6	**Have you been vaccinated for COVID19?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	(If answered as "Yes") ____________										
6a	Date of First dose ____________										
6b	Name of vaccine ____________										
6.1	**Have you been vaccinated with Second dose**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.1a	Date of Second dose ____________										
6.2b	Name of vaccine ____________										
6.2	**Have you experienced any adverse reaction post vaccination**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	(If yes) ____________										
	Please share details including treatment taken for the same and date of complete 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 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 details as may be considered relevant. Information about me/ us may be collected and used by ICICI Prudential Life Insurance Co. Ltd. for the purpose of providing/ offering me/ us promotional material relating to any products and services. I/ We hereby agree that a waiting period as stated in the guidelines and applicable as per the product type, shall be applicable after revival of the policy. 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 with the applicable laws. This form shall be a part of my/ our Life/ Health insurance policy contract.

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) _____

		Date: D D M M Y Y Y Y
		Place: _____
Signature of Witness/ person filling the form	Signature/ thumb impression of the Life Assured/ Policyholder signing in a vernacular language)	

COMP/DOC/May/2022/25/0161