CERTIFICATE OF INSURABILITY & COVID-19 QUESTIONNAIRE

*Policyholder Name: _____ *Policy No.:_____

*Email Address: _____ *Mobile No.:_____ *PAN No.:_____

Bank Account Details: *To ensure hassle free payouts in future, please share your bank account details with us, if not updated. To update fill out below details and provide original cancelled cheque with preprinted account no. & name along with KYC proof (*Annexure -1)*

Bank Name: _____ Account Type: Savings ☐ Current ☐

Account No.: _____ IFSC Code:_____

** I confirm that the above mentioned details are the latest and may be considered by Aegon Life Insurance for updation in its records and for future communication*

Reinstatement Details:

Reinstatement Amount Paid: Rs._____ Date of Payment: _____

Payment Mode: Cash ☐ Cheque ☐ DD ☐ NEFT ☐ Online ☐ Nationality: Indian ☐ NRI ☐

Policyholder Address: _____

Life Assured Address: _____

☐ **Fill below questionnaire of COI for Life policies**

Answer all the following questions related to the Life Assured by ticking Yes or No.(To be answered by Life Assured)
Please note:

1. From Q.3-12 if any question is answered as YES provide DETAILS of the same E.g. onset, duration, treatment, investigation etc. & copies of the same
2. In case additional space is required, please attach separate sheet of paper to this form

Sr. No.	Question	Yes	No	Reason
1	i. Height (Without Shoes)_____ Weight _____			
	ii. Has your weight increase / decreased more than 5 kg in last 12 months? If Yes, Please state the reason			
2	i. Has there been any change in your occupation since date of applying for this Policy?			
	ii. If 2(i) is answered as 'Yes' provide Name of current Employer / Business [Provide relevant questionnaire for hazardous occupations (required when job profile or occupation is changed and is hazardous)]			
3	Do you have any physical deformity/handicap from birth, accident, illness?			
4	i. Have you ever suffered or suffering from Diabetes / High Blood Sugar, High Blood Pressure, Stroke, Paralysis, Epilepsy, Chest pain, Heart attack, Kidney disease, Blood related disorder, High Cholesterol, Any disorder since Childhood, Any specific disorder running in your Family, Respiratory disorder, Digestive disorder, Cancer or Tumor, Mental disorder or Any Congenital defect?			
	ii. Have you ever suffered or suffering from any medical condition not mentioned above?			
	iii. Do you have symptoms for which you are planning to take medical advice?			
	iv. Are you currently on medication for any disease or medical problem other than common cold, influenza?			

Sr. No.	Question	Yes	No	Reason
5	In last five years have you undergone any type of - Investigations or screening like blood test, urine test, X-ray, ECG, TMT, Sonography, CT-scan, MRI or others not mentioned above			
	Hospitalization			
	Surgery			
6	Has any of your parents / siblings before their age of 60 years suffered from Blood Pressure / Diabetes / Heart ailment / Cancer / Kidney ailment / Paralysis / Stroke / Hereditary / Familial disorder (E.g.-Polycystic Kidney disease, Familial Polyposis of Colon etc.)			
7	Were you or your spouse ever tested positive for Hepatitis B or C, HIV, AIDS or any other Sexually Transmitted Disease?			
8	Do you consume Alcohol / Tobacco / Smoke / Drugs? [If 'Yes' please provide the quantity & duration since it is consumed]			
9	Do you participate or intend to participate in any hazardous sporting activities E.g. Mountaineering, Motor racing, Diving, Gliding etc. [If 'Yes' please give details]			
10	**For Female Life Assured Only:**			
	i. Are you pregnant? If 'Yes' please mention how many weeks:			
	ii. Any history of miscarriage/s, ectopic pregnancy			
	iii. Have you ever suffered from any Menstrual disorders/ Menorrhagia/ Fibroids / Any other Gynecological problem			
11	Have you travelled or intend to travel out of India for any purpose other than vacation?			
12	Has any of your proposal for insurance or reinstatement of life / Health / Critical illness/ Personal accident insurance has been declined, postponed, modified or rated by other insurance company?			
13	Please provide the Total Sum Assured of Life insurance policies purchased from other insurance company after issuance of the current policy (including policies in proposal stage, Issued & in lapsed status).			

State whether the Policyholder or the Life to be Insured or Nominee are Politically Exposed Persons. Yes ☐ No ☐

If Yes, please provide the details:

_____

*PEP: Individuals who are or have been entrusted with prominent public functions domestically or by a foreign country or by an international organization, for example Heads of State or government, senior politicians, senior government, judicial or military officials, senior executives of state-owned corporations and important politically party officials OR Family members /close associates who are related or have business relationships with PEP's"

☐ **Fill below questionnaire of COI for Health policies**

If you have answered any question in 'yes' please provide full details at the box provided in the end of questioner (To be answered by Life Assured)					
1. Address (Residence) Name of Life Assured	_____ _____				
Questions	**Primary Life**	**Spouse**	**Child 1**	**Child 2**	**Child 3**
2. Occupation					
2a. Has there been any change in occupation of the Life Assured, since the date of proposal for this policy?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2b. Is the Life Assured presently disabled by illness or injury or is otherwise prevented from performing without any aid or assistance and as a fully and int the same manners as he/ she had been performing at the time of his/ her proposal for insurance?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2c. Has the Life Assured ever or is currently suffering from any illness, impairment, or disability or any surgery not mentioned above?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Does the Life Assured participate or intend to participate in any hazardous sporting activities e.g mountaineering, motor racing, diving, gilding, etc.?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4. Has the Life Assured since the date of proposal for this policy travelled or intend to travel or reside abroad other than on holiday?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5a. Height of Life Assured (cms).	_____ cms	_____ cms	_____ cms	_____ cms	_____ cms
5b. Weight of Life Assured (kgs).	_____ kgs	_____ kgs	_____ kgs	_____ kgs	_____ kgs
5c. Is there a change in weight of more than 5 kg in last 2 years?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6a. Does the Life Assured consume alcohol or nicotine?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6b. Has the Life Assured ever used cocaine, heroin, or other narcotics, marijuana, LSD, or amphetamines except as Prescribed by a physician? If yes, please complete Drug usage Questionnaire.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Has any of the parents/ brothers/ sisters of the Life Assured suffered from or died of heart dieses, stroke, high blood pressure, diabetes mellitus, cancer, kidney disease or paralysis or any other hereditary/ familial disorders such as Huntinton's disease, Polycystic disease or the kidneys or familial polyposis of the colon?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Questions	Primary Life	Spouse	Child 1	Child 2	Child 3
8. In the last 5 years:					
8a. Has the Life Assured consulted any physician or other health practitioner for any illness, other than common cold, fever or influenza lasting for more than 4 days?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8b. Has the Life Assured been told to take advice for any illness, disease or injury or has been admitted as an in-patient in a hospital or clinic except for pregnancy, child birth or routine check up?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8c. Submitted to ECG, X-ray, blood test or other tests?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
9. Has the Life Assured ever been examined or treated for any Heart problem, Hypertension, diabetes, Respiratory problem, Tuberculosis, Digestive disorder, Renal problem, Tumor, Mental disorder or any Gynecological problem?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10. Has the Life Assured ever had to seek advice for Acquired immune Deficiency Syndrome (AIDS) or a test indicating presence of HIV virus?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

State whether the Policyholder or the Life to be Insured or Nominee are Politically Exposed Persons. Yes ☐ No ☐

If Yes, please provide the details:

_____

*PEP: Individuals who are or have been entrusted with prominent public functions domestically or by a foreign country or by an international organization, for example Heads of State or government, senior politicians, senior government, judicial or military officials, senior executives of state-owned corporations and important politically party officials OR Family members /close associates who are related or have business relationships with PEP's"

Declaration & 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 Aegon Life Insurance Company Ltd. (hereafter called "the Company") believing them to be such, will rely and act on them. Furthermore, I hereby irrevocably authorize Basis my answers in this application, there may be change in the amount of premium payable and I accept and agree to pay the revised premium amount that may be chargeable to me by the Company.
Submission of this COI does not mean auto reinstatement of my policy and the same is subject to completion of all the requirements including medical requirements If required raised by the Company. Upon approval by the Company reinstatement of the policy shall be communicated separately to me basis my answers in this application, there may be change in the amount of premium payable and I accept and agree to pay the revised premium amount that may be chargeable to me by the Company. I further agree to pay the outstanding dues including interest and any other charge as may be applicable to reinstate the policy. I understand and agree that the total outstanding dues payable by me mentioned in the reinstatement quotation shall be valid till the validity period and may change thereafter as per the prevailing norms of the Company

I/We hereby irrevocably authorize any organization, institution or individual and third party service providers that has any record or knowledge of my/Life Assured's health or medical or financial status/history to disclose any such information upon request by and to the Company or any of its authorized representatives. I/We authorize 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 heath status in relation to application and claim arising therefrom or request/collect such information, from any doctor or hospital who/which at any time has attended on the person to be insured/policyholder or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured/policyholder and seeking information from any insurer to whom an application for insurance on the person to be insured/policyholder has been made for the purpose of underwriting the proposal and/or claim settlement

COVID-19 (Coronavirus) Exposure Questionnaire

Please answer the following questions with as much detail as possible:

1. Have you, or your family been in close contact with anyone who has been quarantined or who has been diagnosed with novel coronavirus (SARS-CoV-2/COVID-19) ? If yes, please provide details.
   Yes ☐ No ☐

   _____

   _____

2. Have you, or your family ever been serving a notice of quarantine in any form imposed by local health authorities or government or airport authority for possible exposure to novel coronavirus (SARS- CoV2/COVID-19)? If yes, please provide more details like location, dates, quarantine period.
   Yes ☐ No ☐

   _____

   _____

3. Have you been advised to be tested to rule in, or rule out, a diagnosis of novel coronavirus (SARSCoV-2/COVID-19)? Or Are you awaiting the result of a test which has already been submitted for the novel coronavirus (SARS-CoV-2/COVID-19)? Or Have you ever tested positive for the novel coronavirus (SARS-CoV-2/COVID-19)? If yes, provide the date of positive diagnosis.
   Yes ☐ No ☐

   _____

   _____

4. Have you experienced any of the following symptoms within the last 14 days?

   - Any fever
   - Cough
   - Shortness of breath
   - Malaise (flu-like tiredness)
   - Rhinorrhea (mucus discharge from the nose)
   - Sore throat
   - Others

   Yes ☐ No ☐

   If yes, to any of these, please indicate which and provide full information, including date and duration of the symptom

   _____

   _____

5. For healthcare Professionals (e.g., Doctors, Surgeons, Therapists, Nurses, Pathologist, paramedics, Pharmacist, Ward helpers).
   Have you been or do your work duties involve close contact with anyone who has been quarantined or who has been diagnosed with novel coronavirus (SARS-CoV-2/COVID-19)or does your nature of duties involve treatment of novel coronavirus or have you enrolled as Corona virus warrior? If Yes, please provide Medical Specialty and exact nature of duties:
   Yes ☐ No ☐

   _____

   _____

6. Travel Declaration

a. Are you currently residing outside of India?

Yes ☐ No ☐

If Yes, please provide your details:

COUNTRY	CITY	DATE OF TRAVEL	INTENDED DURATION

b. Have you travelled abroad in the past 14 days or intend to travel abroad in next 3 months:

Yes ☐ No ☐

If Yes, please provide your travel details:

COUNTRY	CITY	DATE ARRIVED/ DATE OF ARRIVAL	DATE DEPARTED/ INTENDED DURATION

7. COVID19 Vaccination Details

Have you been vaccinated for COVID19? Yes ☐ No ☐

If Yes,

- Date of administration of the first dose: _____
- Date of administration of the second dose: _____
- Name of Vaccine: _____
- Have you experienced or are you experiencing any adverse reaction post vaccination? Yes ☐ No ☐
    - If yes, please share details including treatment taken for the same and date of complete recovery

      _____

Clients to share Copy of vaccination certificate (or copy of any official documentation confirming complete vaccination & issued by the relevant health authority). Please note self-declarations are not acceptable

Declaration

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

Signed at_____on this day_____of_____, _____

_____

Life Assured Signature

Annexure – 1:

List of KYC Proofs:

OVDs	**ID Proof**	**Address Proof**
Valid Passport	Yes	Yes
Valid Driving License	Yes	Yes
PAN Card	Yes	No
Aadhar card/ Proof of Possession of Aadhaar card	Yes	Yes
Voters identity card issued by Election Commission of India	Yes	Yes
The letter issued by the National Population Register containing details of name, address, etc.	No	Yes
Job card issued by NREGA duly signed by an officer of the State Government	Yes	Yes
Any other document as notified by the Central Government in consultation with the Regulator	Yes	Yes