

ACCIDENTAL RIDER FORM

Name of the Policy holder : _____
 Policy No. : _____
 Date of Request for Endorsement Form : _____
 Registered Address (as on the policy document) : _____
 Registered Contact Number (as on the policy document) : _____
 E-mail Address : _____

Please Select: ADB Rider Form Sum assured amount
 ADDD Rider Form Sum assured amount

1) Since the date of submission of proposal for above policy to the company:

A) Have you suffered from any illness/accident or consulted a Medical Practitioner: Yes No
 If yes, please give details: _____

B) Have you undergone any investigations tests such as Blood Test, X-ray, ECG etc.? Yes No
 If yes, please give details: _____

C) Did you have to take time off from office/ work due to any health condition other than for common cold and cough for more than 5 days? Yes No
 If yes, please give details: _____

D) Has there been any condition/ symptom for which you have yet not sought advice for? Yes No
 If yes, please give details: _____

2) Please mention the Life Assured's current occupation details including designation:

Signature of Proposer:

Signature of Life to be Assured:

Dated:

Place:

Disclaimer

"In the event of any disagreement in interpreting the contents of the format, the format that was printed in Hindi / English version (as the case may be) prevails as per IRDAI Circular No: IRDAI/ Life/ Life Council/ 2013/ 73 dated 29th April 2014"