AEGONLife

CERTIFICATE OF INSURABILITY

Policy No./ Nos.:_____ Contact No:_____ Email:_____

Name of the Life Assured

_____ _____ _____

First Name Middle Name Last Name

Answer all the following questions related to the Life Assured by ticking Yes or No.

	In case additional space is required, please attach separate sheet of paper to this form						YES	NO	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
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 Tumour, 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?								
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				
	YES	NO	YES	NO	YES	NO			
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. Haveyoueversufferedfromany Menstrualdisorders/Menorrhagia / Fibroids / Any other Gynaecological 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/ Personalaccident 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). _____			

The payment against your policy (if any) will be credited, directly to your Bank account through electronic mode of payment. For this purpose, we require your bank details as below for making the payment through NEFT (National Electronic Fund Transfer):

1. Bank:_____ **2. Branch Address:** _____

3. Account Type: Savings/ Current/ Cash Credit/ NRI **4. Account No.:** _____

5. IFSC Code:_____ **6. MICR Code:** _____

I,the LifeAssured/ Policy ownerherebydeclare that tothebest of myknowledge and understanding, the above statements and answers are true and complete inallmanner and sameshallformthe basis of suchreinstatement or change in policy coverage by the Company.
I understand and agree that in case of any concealment, misrepresentation/misstatement of material information in this application, the contract of insurance shall become voidable at option of the Company.
I agree that by reason of this application or bymaking any premium payment, the Company shallnot assume liability of any kind unless it is approved, accepted and communicated to me in writing.

_____ _____
Thumb Impression / Signature of Life Assured Thumb Impression / Signature of Proposer

_____ _____
(Signature ofAgent / Specified Person) Date & Place

Vernacular Declaration
I haveexplained the contents of this declaration to the Proposer/ Life to beAssured in _____(language),asperhis/her choiceandthecontentshavebeenfullyunderstoodbyhim/her.IhaveaccuratelyrecordedtheProposer's/Lifetobeassureds'repliestothe questions in this declaration. I have read out the replies recorded by me to the Proposer/ Life to be Assured and he/ she has confirmed that they are correct.The thumb impression/signature of the Proposer/ Life to be Assured is affixed in my presence.

_____ _____
Name of thedeclarant Signature of the declarant

Date & Place _____

Extract of Section 45 of Insurance Act:
No policy of life insurance shall becalled in question on any ground whatsoever after the expiry ofthree yearsfrom the date of the policy,i.e. from the date of issuance of the policy or the date of commencement of risk or the DATEOF REVIVALOFTHE POLICY or the date of the rider to the policy, whichever islater.
A policy of life insurance maybe called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy,whichever is later,on the ground that any statement of or suppression of a fact material tothe expectancy of the life of theinsured wasincorrectly made in the proposal orother document on the basis of which the policy was issued or revived or rider issued.

COVID-19 (Coronavirus) Exposure Questionnaire

Applicant's Name	Application Number:

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

1. Are you, or have you 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 ever been quarantined due to a possible exposure to novel coronavirus (SARS-CoV-2/COVID-19)? If yes, please provide dates and locations.
   Yes ☐ No ☐

   _____

   _____

3. Have you been advised to be tested to rule in, or rule out, a diagnosis of novel coronavirus (SARS-CoV-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)?
   Yes ☐ No ☐

4. Have you ever tested positive for the novel coronavirus (SARS-CoV-2/COVID-19)? If yes, provide the date of positive diagnosis.
   Yes ☐ No ☐

   _____

   _____

5. 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
- Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhea

If yes, to any of these, please indicate which and provide full information.

6. Travel Declaration
   a. Please provide your travel patterns over the past 14 days:

COUNTRY	CITY	DATE ARRIVED	DATE DEPARTED

   b. Please detail your intended future travel plans for the next 30 days:

COUNTRY	CITY	DATE ARRIVAL	INTENDED DURATION

7. Are you currently in good health?
   Yes ☐ No ☐

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_____, _____

_____

Applicant Signature