Star Union Dai-ichi Life Insurance

A joint venture of Bank of India | Union Bank of India | Dai-ichi Life

DECLARATION OF GOOD HEALTH FORM

Guidelines:

- This form should contain the details of Life Assured.
- 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 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 consent for the revised premium, whichever is later.
- Validity of this DGH is 6 months.

Kindly answer all questions. In case additional space is required, please attach separate sheet of paper to this form.

POLICY NO. | APPLICATION NO.

I. DETAILS OF THE LIFE ASSURED

NAME OF THE LIFE ASSURED/ LIFE TO BE ASSURED

FIRST NAME | MIDDLE NAME

SURNAME

OCCUPATION | NAME OF EMPLOYER/BUSINESS

DURATION OF SERVICE (IN YEARS) | LANDLINE NO.

MOBILE NO.

Are you a resident of jurisdiction outside India? ☐ Yes ☐ No

(If the answer to the above question is 'Yes', kindly fill FATCA/ CRS Form)

Country of Residence

II. HEALTH & LIFESTYLE DETAILS

Answer the following questions in **YES** or **NO**. {If answer to any questions below is YES, please provide details/ treatment report (current or past). Provide relevant questionnaire for hazardous occupations (required when job profile or occupation is changed and is hazardous)

Height: _____ cm Weight: _____ kg

		YES	NO
1	Are you at present in Good Health?	☐	☐
2	Do you have any physical deformity/Handicap or congenital defect/abnormality?	☐	☐
3	During the last five years, have you consulted a doctor or have been advised to undergo any medical investigation or treatment for any medical condition (other than minor cough, cold or flu), or had a surgery or been hospitalized?	☐	☐
4	**Have you ever been diagnosed with, treated for, or advised to seek treatment from any of the following condition? Please use ✓ to indicate which condition(s)**		
	a. Diabetes/Raised Blood sugar, High Blood Pressure/Hypertension, Heart disease, Chest pain, Palpitation, Heart murmur, Heart Attack, Rheumatic Fever, High cholesterol, Disorder of the Heart or blood vessels or undergone heart surgery	☐	☐
	b. Stroke, Epilepsy, Fits, Black-outs, Coma, Paralysis, Multiple Sclerosis Brain Hemorrhage, Any disease of the Brain, Nervous System, Disease of Kidney, Renal Calculi, Bladder or Urinary Tract, reproductive organs, Disorder of the Eye, Ear, Nose, Throat, Asthma, Tuberculosis, Bronchitis, other lungs and respiratory system	☐	☐
	c. Tumor, Cancer, Leukemia, Lymphoma, Cyst, Undergone chemotherapy or radiotherapy, Anemia, Hemophilia, Thalassaemia or any other disorder of the blood, Gout, Arthritis, Back/Neck/Joint Pain, Slip Disc and other musculoskeletal disorder, any disorder of the digestive system such as Ulcer, Colitis or disease of the liver of pancreas. Goitre/Thyroid/Other Endocrine or gland diseases, Depression, Schizophrenia or any Mental Disorders/psychiatric ailment, Skin disease or disorders, Liver or Gall Bladder problems/ Jaundice/Hepatitis	☐	☐
5	Are you currently taking, or have you previously taken, any medication or treatment for a continuous period of more than 10 days for any condition, other than for minor coughs, cold, flu, typhoid?	☐	☐
6	Were you or your spouse ever tested positive for Hepatitis B or C, HIV, AIDS or other sexually transmitted disease	☐	☐
7	Do you consume alcohol or tobacco or smoke or have any habit for drugs or narcotics?	☐	☐
8	For Female Applicants Only:		
	a. Are you Pregnant? If yes, please mention how many weeks:	☐	☐
	b. Have you suffered from any gynecological problem or illness related to breasts, uterus or ovary?	☐	☐
	c. Have you undergone or been advised to undergo Mammogram, biopsy, or operation of breast, uterus or any other gynecological test or test related to irregular menstruation.	☐	☐

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9 Have you ever been tested positive for novel corona virus, or quarantined or in contact/cohabitation with any person who has been tested positive/quarantined or symptomatic for COVID 19. If yes, please provide details ☐ ☐

_____

10 Have you travelled in and/or out of the country 15 days prior to the Declaration of Good Health Form signing date or are you planning to travel in and/or of the country in the next 3 months.. If yes please provide details ☐ ☐

Please provide your travel history over the past 15 days prior to the Good health declaration signing date:

Country	City	Date Arrived	Date Arrived

Please provide your travel history over the past 15 days prior to the Good health declaration signing date:

Country	City	Tentative Travel Date/Month/Year	Intended duration of Stay

11 Have you been advised to be tested to rule in, or rule out, a diagnosis of novel coronavirus (COVID-19)? Or, are you awaiting the result of a test which has already been submitted for the novel corona virus (COVID-19)? If yes, give details ☐ ☐

DECLARATION OF THE LIFE TO BE ASSURED/PROPOSER (IN CASE OF MINOR LIFE TO BE ASSURED)/DECLARATION OF THE LIFE ASSURED/PROPOSER (IN CASE OF MINOR LIFE ASSURED)

I _____ do hereby, declare that the answers and statements made on this health declaration are full, complete and true in every particular and agree and declare that these statements and this declaration along with the proposal for insurance will form basis of the contract. All material facts, being facts, which may influence the assessment of this risk, have been disclosed in this health declaration. I understand that failure to make such disclosure shall render the contract null and void. I/We understand that the Company is not able to offer any tax advice on CRS/FATCA or its impact. I/We shall seek advice from professional tax advisor. I/We further agree to submit a new form within 30 days if any information or certification on this form becomes incorrect. I/We agree that as may be required by domestic regulators/tax authorities the Company may also be required to report, reportable details to CBDT or close or suspend my account.

Dated at _____ on the _____ day of _____ 20_____

Signature of Witness: _____

Name of Witness: _____

Address of Witness: _____

_____

Signature/Thumb Impression of the Life Assured/Proposer

VERNACULAR DECLARATION OF THE LIFE TO BE ASSURED/PROPOSER (IN CASE OF MINOR LIFE TO BE ASSURED)/VERNACULAR DECLARATION OF THE LIFE ASSURED/PROPOSER (IN CASE OF MINOR LIFE ASSURED)

I _____ hereby, declare that I have explained the contents of the proposal form to the Life Assured/Life to be Assured in _____ language and I have read out the answers to the questions dictated to me and that the Life Assured/Life to be Assured has put his signature/thumb impression on the proposal form after fully understanding the contents thereof.

Dated at _____ on the _____ day of _____ 20_____

Signature of Witness: _____

Name of Witness: _____

Address of Witness: _____

_____

Signature/Thumb Impression of the Life Assured/Proposer

Protecting Families, Enriching Lives!