

### Declaration of Health Statement

**(For proposal form pending for more than 90\* days)**

- NOTE** – 1. \* 90 days would be applicable from the day of signing the proposal form. This would include all kinds of holidays including national holidays and weekends.  
 2. The information solicited below pertains to the period from the day you filled in the original proposal form till date.

Application No / Proposal No	
Name of Life to be Assured	
Date of Birth	
Address of Life to be Assured	

#### Personal Health details of the Life to be Assured:

Kindly provide answers to all of the following questions.	Please tick ( ✓ )	Mention details, if any.
1) Between the date of proposal and till date is there any change in your occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2) Are you currently in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3) Have you undergone any of the below mentioned in the past 90* days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
a. Hospitalisation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Operation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. X-Ray or any other pathological Investigation.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If answer to any of the above-mentioned question is "Yes", please fill in a fresh proposal form. (Contact your FC/ BDM/ CAM /our branch office to get a proposal form). If answer to all the above question(s) is "No", then please proceed to answer the below questions.		
4) Have you ever tested positive for HIV / AIDS or Hepatitis B or C, or tested/ treated for other sexually transmitted diseases or are you awaiting results of any of the above test?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5) Have you suffered from any of the following?		
a. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Disorder of the liver	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Kidney or urinary disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Digestive disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Paralysis or multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
h. Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
i. Blood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
j. Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
k. Cancer or a tumour	<input type="checkbox"/> Yes <input type="checkbox"/> No	

l. Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
m. Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
n. Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
o. Any nervous disorder or mental condition, depression or psychiatric disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
p. Any recurrent medical condition or disability (including eye or ear disorder)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
q. Thyroid disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6) Did you have any accident or injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7) Have you traveled abroad during this period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8) Have you ever had an application for a fresh insurance cover/renewal/ reinstatement of life or accident insurance declined, postponed, rated up or in any way modified, in this period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9) For female lives only.			
a. Are you presently pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b. Have you had any abortion or miscarriage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
c. Have you suffered or are you suffering from any disease of breast, ovaries or uterus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

❖ **An incomplete Statement will not be considered valid.**

**Declaration of Life to be Assured:**

I agree and understand that the information given herein is true and complete in all respects and will form an integral part of the proposal made by me for an insurance policy from HDFC Life Insurance Company Limited. As on date, I do not currently plan to visit a doctor or undergo any medical investigations within the next few days. Failure to disclose any material fact known to me may invalidate the contract.

Signature/thumb impression  
(Life to be Assured)

Date:.....  
Place:.....

Signature/thumb impression  
(Proposed Policy Holder if different  
from Life to be Assured)

Date:.....  
Place:.....

**In the case of thumb impression\ signature in vernacular language:**

In case of thumb impression of the Life to be Assured the same should be attested by a person of standing whose identity can be easily established, but unconnected with the Company and this declaration should be made by him.

I hereby declare that I have explained the contents of this form to the Life to be Assured in \_\_\_\_\_ language and have truthfully recorded the answers provided to me and that the Life to be Assured has signed /affixed thumb impression(s) above after fully understanding the contents thereof.

Signature

Date:.....  
Place:.....

Name and address of the declarant \_\_\_\_\_