



SECTION 3 HEALTH STATUS



PLEASE ANSWER ALL QUESTIONS BY CHECKING EITHER THE YES OR NO BOX

1. Are you now in good health and entirely free from any mental or physical impairments or deformities? YES NO

2. Height _____ (Cm.) Weight _____ (Kg.)

How much weight have you lost or gained over the last 12 months? _____ (Kg.)

Reason for weight change: _____

3. Have you ever suffered or do you now suffer from:

a) Diseases of the circulatory system (e.g. heart trouble, chest pain, rheumatic fever, high blood pressure, diseases of the arteries and veins)? YES NO

b) Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia or emphysema)? YES NO

c) Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)? YES NO

d) Diseases of the gastrointestinal system (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B, hepatitis C or other disorders of the liver, disorders of the gall bladder)? YES NO

e) Diseases of the nervous system or mental disorders (e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown, depression or other mental or psychiatric disorder)? YES NO

f) Diabetes mellitus, cancer or tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes or skin? YES NO

g) Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands? YES NO

h) Any other diseases or ailments not mentioned above? _____

4. Have you or any of your immediate family members (father, mother, brother, or sister) have/had cancer, heart attack, or stroke and at what age? Prior to age 60? YES NO

5. Have you ever had or been advised to have hospital treatment or surgery? YES NO

6. Have you ever had or been advised to have a blood test for AIDS or an AIDS-related condition or have you ever been refused as a blood donor? YES NO

7. In the past 5 years, have you consulted a physician for any reason or have you had any investigation such as blood or urine tests, X-rays, electrocardiograms, ultra sonograms, CT scans or biopsy, other than for routine employment or immigration purposes? YES NO

8. Have you ever received or do you now receive any personal accident, disability benefit, or disability-related payments? YES NO

9. Are you at present or any time in past were on any medication, special diet, or treatment? YES NO

10. Have you ever taken narcotics or other habit forming drugs or been treated or advised in connection with your alcohol consumption or the taking of drugs? YES NO

11. Do you participate or do you intend to participate in any hazardous sports or activities such as motor sports, climbing, parachuting, hang-gliding, or aviation except as a fare-paying passenger? YES NO





12. Are you pregnant (for female only)? If yes, please state how many months. Please state if you had any pregnancy related complication during your previous pregnancy/delivery? YES NO
13. Have you smoked or used any substance or product containing tobacco, nicotine or marijuana? YES NO

If yes, please state duration and average daily consumption and type: _____

14. Name and address of your regular medical consultant:

If you answered "yes" to any of the questions numbered 1 to 13 (in Section 3 Health Status), please give complete details (including dates, duration and treatment, names and addresses of physicians) on the reverse of this form and include your signature and the date.

SECTION 4 PERSONAL INFORMATION COLLECTION STATEMENT

The information you provide to us is collected to enable us to carry on insurance business and may be used for the purpose of (i) any insurance or financial related product or service or any alterations, variations, cancellation or renewal of them; (ii) any claim or analysis of it; and may be transferred to any related company or any other company carrying on insurance or reinsurance related business or any intermediary or claims investigator or other service provider providing services relevant to insurance business or any association or federation of insurance companies that exists or is formed from time to time.

You have the right to obtain access to and to request correction of any personal information concerning yourself held by Bajaj Allianz. Requests for such access can be made to the Company.

SECTION 5 AGREEMENT

I hereby declare and warrant that the above statements are true and complete in all respects and that there is no other information which is relevant to my application for insurance for myself or any other person to be insured that has not been disclosed to you. I agree that this proposal and the declarations shall be the basis of the contract between me and Bajaj Allianz and I agree to accept a policy, subject to the conditions prescribed by Bajaj Allianz.

I hereby apply for Critical Illness Insurance under Individual Insurance Policy issued to me by Bajaj Allianz, subject to all terms, conditions and provisions of the policy.

I understand that no insurance can be granted prior to approval by Bajaj Allianz.

I understand that the insurance coverage will commence after the first premium is received by Bajaj Allianz.

I authorize any physician, nurse, hospital official or employee to disclose to the Bajaj Allianz any and all information regarding my medical history.

 APPLICANT'S SIGNATURE

_____/_____/_____
 DATE (Day/ Month/ Year)

INSURANCE ACT 1938 SECTION 41 – Prohibition of Rebates. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer. ANY PERSON MAKING DEFAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO FIVE HUNDRED RUPEES.





If you answered "yes" to any of the questions numbered 1 to 13 (in Section 3 Health Status), please give complete details (including dates, duration and treatment, names and addresses of physicians)



Applicants Signature

