

APPLICATION FOR PERSONAL HEALTH STATEMENT

(Kindly fill in Block Letters)

Life Assured Name: _____ Policy Holder Name: _____

Policy Number: _____ Contact Number (home): _____

Mobile Number: _____ Email ID: _____

Date of Birth of Life Assured (DD/MM/YYYY): _____

Please in boxes to indicate choice

1.	Height	<input type="text"/> <input type="text"/> Feet	<input type="text"/> <input type="text"/> Inches	OR	<input type="text"/> <input type="text"/> <input type="text"/> Centimeters	Weight	<input type="text"/> <input type="text"/> <input type="text"/> Kg	
2.	Apart from minor ailments such as colds and flu have you received any treatment from, or consulted with, any doctor or specialist or been hospitalized in the last 5 years						<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you ever suffered from or currently under treatment for:						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	a. Diabetes?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b. High Blood Pressure?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	c. Stroke, chest pain, heart attack, or any heart disease?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	d. Asthma or any other respiratory disorder?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	e. Epilepsy, Paralysis, Parkinson's Disease, Multiple Sclerosis or any other nervous disorder?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	f. Liver Disease, Gall Bladder Disease or any other digestive disorder?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	g. Kidney disease?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	h. Blood disorder, endocrine disorder or any musculoskeletal disorder?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	i. A tumor, abnormal cyst, any cancers?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	j. Anxiety, depression or any other mental disorder requiring treatment with antidepressant?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	k. A positive test for HIV/AIDS, Hepatitis (Other than Hepatitis A and E) or any sexually transmitted diseases?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Has your proposal for life insurance ever been declined, postponed, withdrawn or accepted at an increased premium?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Are there any other circumstances not mentioned above which may affect the risk of insurance on the person to be Insured?						<input type="checkbox"/> Yes	<input type="checkbox"/> No

If answer to any of the above questions is "Yes", please give details and provide reports (if available):

6.	Details of family doctor (To be filled if any of the above questions have been ticked "Yes")																								
Name, address and contact details of family physician																									
	Landmark																								
	City																								
	State																								
	PIN																								
	Mobile										Tel <small>(With STD Code)</small>														
	Email																								

7.	Family History			
Family Member	Current state of health	Current Age	If deceased, cause of death	Age at death
Father		<input type="text"/> <input type="text"/> yrs		<input type="text"/> <input type="text"/> yrs
Mother		<input type="text"/> <input type="text"/> yrs		<input type="text"/> <input type="text"/> yrs
Brother		<input type="text"/> <input type="text"/> yrs		<input type="text"/> <input type="text"/> yrs

Brother		<input type="text"/> <input type="text"/> <input type="text"/> yrs	<input type="text"/> <input type="text"/> <input type="text"/> yrs
Sister		<input type="text"/> <input type="text"/> <input type="text"/> yrs	<input type="text"/> <input type="text"/> <input type="text"/> yrs
Sister		<input type="text"/> <input type="text"/> <input type="text"/> yrs	<input type="text"/> <input type="text"/> <input type="text"/> yrs

8.	For Female lives only:		
	i. Have you ever suffered/are you suffering from any gynaecological problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	ii. Are you pregnant at present? If "Yes" what is the expected date of delivery? <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	iii. Have you had any complications, miscarriage, medical termination of pregnancy or Caesarian Section?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Details of questions ticked as "Yes" _____			

9.	Habits			
Substance Consumed		(If "Yes", Please tick the substance and quantity consumed)	Quantity/day	Consuming Since
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarette <input type="checkbox"/> Bidi <input type="checkbox"/> Cigar <input type="checkbox"/> Pan Masala	<input type="text"/> <input type="text"/> Pouches/day	<input type="text"/> <input type="text"/> <input type="text"/> Years
			<input type="text"/> <input type="text"/> Sticks/day	
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Hard Liquor	<input type="text"/> <input type="text"/> ml/day	<input type="text"/> <input type="text"/> <input type="text"/> Years
Drugs not prescribed by doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tranquilizers <input type="checkbox"/> Stimulants <input type="checkbox"/> Sedatives <input type="checkbox"/> Narcotics	<input type="text"/> <input type="text"/> _____ /day	<input type="text"/> <input type="text"/> <input type="text"/> Years
		<input type="checkbox"/> Others If others, specify <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

10.	Do you take part or intend to take part in parachuting/hand gliding/scuba diving/mountaineering/ car racing/flying other than as a bonafide passenger/any other hazardous pastimes. Please specify _____ (If "Yes", please complete respective questionnaire)	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Are you planning to travel in the next one year or reside abroad other than on holiday? If "Yes", please provide details along with duration of stay _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Declaration by the Life Assured/Applicant

I hereby declare and agree that the above mentioned particulars/answers are complete and true to the best of my knowledge. I also authorize the company to obtain, if necessary, confidential reports from the doctor /clinics / hospital that I have referred above or on my any medical reports done by IDBI Federal Life Insurance or any other relevant medical reports submitted by me.

I agree that this form will constitute part of my application for life assurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of Life Assured/Applicant: _____

Date: _____

Place: _____

Vernacular Declaration

I have explained the contents of this proposal to the Proposer Mr. /Ms _____ having applied with proposal no. _____ in (Language) and ensured that the contents have been fully understood by him /her. I have accurately recorded the Proposer's responses to the information sought in the proposal form and I have read out the responses to the Proposer and he/she has confirmed that they are correct.

Signature of the person making the declaration: _____

Name of Declarant: _____

Address: _____

Date: _____

Place: _____