17M PERSONAL HEALTH DECLARATION FORM

ICICI PRUDENTIAL LIFE INSURANCE

GUIDELINES:

- Insurance is a contract made in utmost 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 date of receipt of full premium amount by the company or the receipt of consent for revised premium, whichever is later
- Increase in Sum Assured / Addition of rider will be effective from the next billing cycle
- Addition of life / lives will be effective from the policy anniversary falling after the final underwriting decision or the receipt of full premium by the company or the receipt of consent for revised premium, whichever is later
- Validity of this Personal Health Declaration is three months
- Increase in Sum Assured / Addition of Rider / Addition of Life Assured are product specific. Please refer to the Policy Document for details.

personalhealthdeclaration

Policy No.: ..... **Date:** DD/MM/YYYY

Name of the Life Assured: .....
(Primary Life in family floater plans) First Name Middle Name Last Name

Name of the Policy Holder: .....
First Name Middle Name Last Name

Address .....

.....

.....

City ..... State ..... Country ..... PIN CODE .....

Telephone with STD code ..... **Mobile Number** .....

Email ID .....

Policy Inception Date: DD/MM/YYYY **Date of Birth of Primary Life** (For Family Floater plans)**:** DD/MM/YYYY

I, herewith, apply for (Please tick only one)**:**

- ☐ Revival of the Policy (For Family floater plans, please share the details of all the lives)
- ☐ Increase my Health/ Rider Sum Assured from Rs. _____ to Rs. _____ (allowed for select plans)
- ☐ Addition of Rider (allowed for select plans)
- ☐ Addition of Life/ Lives to be Assured (in family floater plans)

1. DETAILS OF THE LIFE / LIVES TO BE ASSURED (to be filled only when Life to be Assured is to be added in the existing policy)

	SPOUSE	CHILD 1	CHILD 2	CHILD 3
a) Name	.....	.....	.....	.....
b) Date of Birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
c) Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
d) Marital Status	.....	.....	.....	.....
	U – Unmarried; **M** – Married; **W** – Widower; **D** – Divorced			
e) Nationality	☐ Indian ☐ Non- Indian	☐ Indian ☐ Non- Indian	☐ Indian ☐ Non- Indian	☐ Indian ☐ Non- Indian
f) Residential Status	☐ I ☐ N	☐ I ☐ N	☐ I ☐ N	☐ I ☐ N
	I – Resident Indian, **N** – Non- Resident Indian			
g) Age Proof	.....	.....	.....	.....
	Passport - **PSPT**; Driving Licence - **DL**; School/ College Certificate - **SC**; Others - Pls specify			
h) Education	.....	.....	.....	.....
	Uneducated – **UEDU**; Below 10th – **<SSC**; 10th – **SSC**; 12th – **HSC**; Graduate – **GRAD**; Post Grad – **PGD**; Diploma – **DIP**			
i) Qualification	.....	.....	.....	.....
	Manager – **M**; Chartered Accountant – **C**; Doctor – **D**; Engineer – **E**; Advocate – **L**; Others (specify)			
j) Occupation	.....	.....	.....	.....
	Salaried – **SP**; Business – **BSEM**; Professional – **PROF**; Student – **STDN**; Housewife – **HSWF**; Retired or Pensioner – **RETD**; Self Employed – **SELF**; Agriculture – **AGRI**; Others – **OT**			
k) Organization Type	.....	.....	.....	.....
	MNC; Public Ltd; Private Ltd; Partner or Proprietor; Govt; Trust; Others (specify)			
l) Name of Org	.....	.....	.....	.....
m) Years in Current job	.....	.....	.....	.....
n) Annual Income	.....	.....	.....	.....

2. DETAILS OF THE RIDERS TO BE ADDED

Rider Name	Term (years)	Sum Assured (Rs.)	Premium (Rs.)

3. PERSONAL DETAILS OF THE LIFE / LIVES TO BE ASSURED

** For Single Life plans, please fill the details under Primary Life only. For Family Floater plans, provide details for all the lives.*

	Primary Life	Spouse	Child 1	Child 2	Child 3
A. Height (cms)	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐
B. Weight (kgs)	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐

C. Life Style Details	Primary Life		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
i Is your occupation associated with any specific hazard (e.g. chemical factory, mines, explosives, radiation, corrosive chemicals, working at heights, diving etc.)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ii Are you employed in the armed, paramilitary or police forces?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
iii Do you take part in activities or have hobbies that could be dangerous in any way?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
iv Do you consume or have ever consumed Tobacco, Alcohol or any Narcotic? (If yes, specify the quantity per day & no. of years since consuming on a separate sheet)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
D. Health Details										
i Do you have any congenital defect/ abnormality?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ii Do you have any physical deformity /handicap or use any mechanical/ physical assistance for mobility?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
iii In the last 5 years, have you for any illness or injury been admitted to hospital for 2 days or more or received medical treatment for continuous 7 days or more or undergone any surgical procedures or diagnostic tests (including mammogram and PAP smear) or medical examinations with abnormal results or have you been advised to undergo any test or investigation or surgery?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
iv Are you aware of or have you ever been treated or hospitalized for Cancer, Tumour, Cyst or any other growth?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
v Any Ailment/ Injury/ Accident requiring Treatment/ Medication for more than a week?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
vi In the last 2 years, have you availed leave on medical grounds for over 2 consecutive days?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
E. Have you ever suffered or are suffering from any of the following										
(a) Diabetes/ High Blood Sugar	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(b) High/Low BP (Blood Pressure)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(c) Disorders of Eye, Ear, Nose, Throat including defective sight or speech or hearing or discharge from ears?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(d) Change in weight of 10 kgs or more in the last six months?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(e) Symptoms/ ailments relating to Brain, Mental/ Psychiatric ailment, Parkinsonism, Multiple Sclerosis, Nervous system,Stroke, Paralysis, or Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(f) Asthma, Bronchitis, Blood Spitting, Tuberculosis or other Respiratory disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(g) Anemia, Blood or Blood related disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(h) Musculoskeletal disorders such as Arthritis, recurrent back pain, slipped disc or any other disorder of Spine, Joints or Limbs or Leprosy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(i) Were you or your spouse ever tested for Hepatitis B or C, HIV/AIDS or any other Sexually Transmitted Disease?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(j) Chest pain, Palpitation, Rheumatic fever, heart murmur, heart attack, shortness of breath or any other heart related disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(k) Symptoms/ ailments relating to kidney, bladder, prostate, testes, scrotum or any other disorders of urinary system	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(l) Gastritis, Stomach or Duodenal Ulcer, Hernia, Liver disease, Jaundice, Hepatitis, Fistula, Piles or any other disease or disorders of the Gastro-Intestinal System.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(m) Thyroid disorder or any other disease or disorder of the Endocrine system	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(n) Any other illness or impairment not mentioned above	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
F. Female lives only (Strike off if not applicable)										
i Have you ever suffered /are you suffering from Gynecological problems?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ii Are you Pregnant at present? If yes, mention the duration in weeks	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
iii Any complications, miscarriage, medical termination of pregnancy or Caesarian?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
iv Have you ever undergone any investigation or treatment or received medical advice or consulted a physician for:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
a. Any disease or disorder of the Cervix, Uterus, Ovary (ies) or Vagina, abnormal bleeding, Cancer or abnormal growth?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. Any disease or disorder of the Breast(s) such as Breast Lump/cyst, Fibrocystic disease, Nipple changes or discharge, cancer or growth?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. IF ANSWER TO ANY OF THE QUESTIONS FROM 3C. TO 3F. IS YES, PLEASE PROVIDE FOLLOWING DETAILS ON A SEPARATE SHEET:

(i) Name of Life to be insured
(ii) Name & Address of treating doctor
(iii) Nature of Ailment/ Exact Diagnosis
(iv) First Date of Diagnosis
(v) Details of Symptoms (Onset, Intensity & Duration)
(iv) List of prescriptions or medicines
(vii) Further planned consultation (if any)

5. HAS THE LIFE ASSURED CHANGED HIS/HER OCCUPATION/ RESIDENCE/ AVOCATION FROM THE DATE OF POLICY ISSUANCE/ LAST REVIVAL?

If yes, is the occupation (e.g. chemical factory, mines, explosives, radiation, corrosive chemicals, etc.)/ avocation (e.g. aviation, other than as a fare paying passenger, diving, mountaineering, any form of racing, etc.) associated with any specific hazard/ risk.

Please give details: .....

6. WHAT IS THE STATUS OF OTHER PROPOSAL/ REVIVAL APPLICATION (IF ANY), FOR AN INSURANCE POLICY (IES) ON THE LIFE OF THE LIFE ASSURED WITH ICICI PRUDENTIAL OR ANY OTHER INSURANCE COMPANY, AFTER THE DATE OF PROPOSAL OF THIS POLICY/ LAST REVIVAL?

Policy or Proposal No.	Company Name	Year of Issue / Application	Medical Policy		Annual Premium (Rs.)	Basic Sum Assured (Rs.)	Basic Plan – Decision (Std. / With Extra Premium / Postponed/ Declined / Not Completed)	Mention names of Riders and Decision (Std. / With Extra Premium /Postponed/ Declined / Not Completed)	In Force/ Lapsed (Mention year of Lapse / Revival Applied for)
			Yes	No					

• Please attach a separate sheet in case the space is inadequate

DECLARATION AND AUTHORISATION

I/We declare that I/We have answered the questions in the proposal form after being explained by the advisor of the ICICI Prudential Life Insurance Company Limited, (hereinafter referred to as 'the Company') and have fully understood the nature of the questions including health related questions and the importance of disclosing all material information while answering such questions. I/We further declare that the answers given by me/us to all the questions in the proposal form and the information given to the Medical Examiner of the company as to the state of health and habits of the life/lives to be assured are true and complete in every respect and that I/We have not withheld any material information or suppressed any material fact. I/ We have made no statement to the Insurance Advisor, medical examiner, or any other person associated with ICICI Prudential Life Insurance Company Limited which in any way modifies the answer and statements on this application. I/We undertake to notify the company of any change in the state of health of the life / lives to be assured or as to his/their occupation(s) subsequent to the signing of this proposal and before the acceptance of the risk by the company. I/We also understand that in case of any mis-statement or suppression of material information or where the Company is not notified of the change in health, the Company has the right to repudiate the claim under the policy. The policy shall become void where it is found that the policy was issued on the basis of fake/tampered documents and/ or proofs. I/We also certify that I/We have read and understood the Benefits Illustrations as published by the company that were handed over to me/us along with this proposal form. I/We also understand that the terms and conditions including the premium and the benefits payable under the policy are subject to variation in accordance to the applicable laws. I/ We confirm that all premiums will be paid from bonafide sources.

I/we agree that we will not use fraudulent means for making claims. I/we also agree that if we do it, the company will terminate the contract.

I/We hereby authorize ICICI Prudential Life Insurance Co. Ltd. to conduct screening/confirmation/reconfirmation of overall status of the life /lives to be insured including the health status through medical examinations which may include Laboratory tests, Cardiology, Radiological investigations and other medical tests including blood tests to detect bacterial/viral/fungal infections. I/We hereby give my/our consent to undergo HIV1/2 test. I / We am/ are aware that this test is only for screening purpose and not confirmatory for HIV/AIDS.

The company reserves the right to accept, decline or offer alternate terms on my proposal for life Insurance.

In order to enable the company to assess the risk under this proposal and any time thereafter, I/We hereby, authorize the past and present employers(s)/ business associates/ medical practitioner/ hospital and medical source/ any life and non-life insurance company/or organization or Life Insurance Association's medical register to release to the Company and the Company to release to any life and non-life insurance company/or Life Insurance Association or medical register, such details and provide the records of employment/business or other details as may be considered relevant.

This proposal form shall be a part of the life insurance policy contract, in case of its acceptance by the Company

Primary Life | Spouse | Child 1 | Child 2 | Child 3 | Proposer (If different from lives to be insured)

_____ _____ _____ _____ _____ _____

Signature/thumb impression of the **Life / Lives to be insured** (Not required for Life/ Lives Assured below 18 yrs of age)

Signature of Advisor _____ (If thumb impression is provided by life to be asssured then it has to be witrnessed by the advisor)

Date .....DD/MM/YYYY..... Place .....

ACKNOWLEDGEMENT SLIP

This is to acknowledgement the receipt of Personal Health Declaration Form

Policy Number: ..... **Date:** .....DD/MM/YYYY.....

Received By .....

STAMP & TIME

DECLARATION AND AUTHORISATION

Section 41 of the Insurance Act 1938 (4 of 1938): (1) 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 or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer: Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on hi s own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer. (2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to five hundred rupees.

Section 45: No policy of life insurance effected before the commencement of this Act shall after the expiry of two years from the date of commencement of this Act and no policy of life insurance effected after the coming into force of this Act shall after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy-holder and that the policy-holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose. Provided that nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.

DECLARATION

Applicable when the Proposer is illiterate or suffering from disability due to which writing is restricted or the proposer has signed in vernacular language. Note: Must be witnessed by someone other than the advisor/agent/employee of the Company.

I (Full name of Witness) _____ (Relation with Proposer) _____ adult and inhabitant of (Address) _____ do hereby declare that I have read and explained the contents of this form to the Proposer and he/she/they have understood the same.

_____

(Signature of Witness)

FOR OFFICE USE ONLY:

☐ **ER** | **Request submitted by** ☐ **C** ☐ **S** ☐ **CR** ☐ **CS**

Spaarc Call ID ..... **Date:** DD/MM/YYYY

Scanning Cabinet ..... **Received By** .....

Remarks .....

STAMP & TIME

Kindly call our Customer Service Number 1860 266 7766 (Local charges apply)
Call Center timings: 10.00 A.M. to 7.00 P.M. Monday to Saturday (except national holidays)

ICICI PRUDENTIAL LIFE INSURANCE

Communication Address
ICICI Prudential Life Insurance Co. Ltd., Unit No. 1A & 2A, Raheja Tipco Plaza, Rani Sati Marg, Malad (East), Mumbai 400097.

COVID-19 DECLARATION FORM

ICICI PRUDENTIAL LIFE INSURANCE

Guidelines:
- ✓ This form should contain the details of Life assured
- ✓ Insurance is a contract made in utmost good faith, trusting the proposer and the life assured to disclose all the relevant (material) facts, in response to the questions in this form
- ✓ Validity of this declaration is 30 days from the date of declaration
- ✓ This form can be used for all contract servicing and new business application change requests.

Barcode

Policy No./ Nos: ______ ______ ______ **Date:** D D M M Y Y Y Y

Name of the Life Assured: Mr./Ms./Mrs. First Name Surname

Name of the proposer: (If different from the Life Assured) Mr./Ms./Mrs. First Name Surname

Contact numbers: STD Residence STD Office Ext. ISD Mobile

E-mail ID:

For life policies, please provide details of primary life assured only. For health policies, please provide details of all lives covered.

Please provide the following information:

Sr. No.	Questions	Primary Life Assured Yes	Primary Life Assured No	Spouse Yes	Spouse No	Child 1 Yes	Child 1 No	Child 2 Yes	Child 2 No	Child 3 Yes	Child 3 No
1	**Have you ever been tested positive for COVID-19?** If your answer to the above question is yes, please answer the next question.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1.1	**Are you fully recovered?** If your answer to the above question is yes, please answer the next question.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1.2a	**Date of diagnosis** ________										
1.2b	**Date of recovery** ________										
1.3	**Were you hospitalized for COVID-19 treatment?** ________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	**In the last 1 months have you or any of your family member been self-isolated with symptoms on medical advice? (excluding mandatory government orders to remain at home)**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	**In the last 1 month did you have persistent cough, fever, sore throat, nausea, vomiting, diarrhea, difficulty in breathing, loss of smell and taste any other symptoms of coronavirus (COVID-19) and advised to do a COVID test or you/your family member have been in contact with an individual suspected or confirmed to have COVID-19?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	**Do you work in an occupation like health care worker/Corona warrior Include (general practitioners, doctors, hospital doctors, surgeons, therapists, nurses, pathologist, paramedics, pharmacist, ward helpers, individuals working in hospitals/ clinics having novel coronavirus (SARS-CoV-2/COVID-19) Ward) where you have a higher risk to get in close contact with COVID-19 patients or with coronavirus contaminated material?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	**Are your currently residing outside of India**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.a	Name of country ________										
5.b	City ________										
5.c	Date of travel DD/MM/YYYY										
5.d	Intended duration (in Months)										
5.1	**Have you travelled abroad in past 14 days**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Country 1	Country 2	Country 3
5.1a Name of country ________	5.1a Name of country ________	5.1a Name of country ________
5.1b City ________	5.1b City ________	5.1b City ________
5.1c Date Arrived DD/MM/YYYY	5.1c Date Arrived DD/MM/YYYY	5.1c Date Arrived DD/MM/YYYY
5.1d Date Departed DD/MM/YYYY	5.1d Date Departed DD/MM/YYYY	5.1d Date Departed DD/MM/YYYY

Sr. No.	Questions	Primary Life Assured Yes	Primary Life Assured No	Spouse Yes	Spouse No	Child 1 Yes	Child 1 No	Child 2 Yes	Child 2 No	Child 3 Yes	Child 3 No
5.2	**Do you intend to travel abroad in next 3 month**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Country 1	Country 2	Country 3
5.2a Name of country ________	5.2a Name of country ________	5.2a Name of country ________
5.2b City ________	5.2b City ________	5.2b City ________
5.2c Date Arrived DD/MM/YYYY	5.2c Date Arrived DD/MM/YYYY	5.2c Date Arrived DD/MM/YYYY
5.2d Intended duration (in Months) DD/MM/YYYY	5.2d Intended duration (in Months) DD/MM/YYYY	5.2d Intended duration (in Months) DD/MM/YYYY

Sr. No.	Questions	Primary Life Assured Yes	Primary Life Assured No	Spouse Yes	Spouse No	Child 1 Yes	Child 1 No	Child 2 Yes	Child 2 No	Child 3 Yes	Child 3 No
6	**Have you been vaccinated for COVID19?** (If answered as "Yes") ________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6a	Date of First dose ________										
6b	Name of vaccine ________										
6.1	**Have you been vaccinated with Second dose**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.1a	Date of Second dose ________										
6.2b	Name of vaccine ________										
6.2	**Have you experienced any adverse reaction post vaccination** (If yes) ________ Please share details including treatment taken for the same and date of complete recovery ________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

DECLARATION AND AUTHORISATION

I/We declare that I/We have fully understood the questions in the form and the importance of disclosing all material information while answering such questions. I/We further declare that the answers given by me/us to all the questions in the form and the information given to the Medical Examiner of the Company as to the status of COVID-19 and habits of the Life Assured are true and complete in every respect and that I/We have not withheld any material information or suppressed any material fact. I/ We have made no statement to the Insurance Advisor, Medical Examiner, or any other person associated with ICICI Prudential Life Insurance Company Limited which in any way modifies the answers and statements in this form. I/We undertake to notify the Company of any change in the status of COVID-19 of the Life Assured or as to his occupation subsequent to the signing of this form and before the acceptance of the risk by the company for revival / Addition of Rider/ increase in Life/ COVID-19 Sum Assured

I/We hereby authorize ICICI Prudential Life Insurance Co. Ltd. to conduct screening/ confirmation/ reconfirmation of overall status of the Life Assured including the COVID-19 status through medical examinations which may include Laboratory tests, Cardiac, Radiological investigations and other medical tests including blood tests to detect bacterial/viral/fungal infections. I/We hereby give my/our consent to undergo HIV1/2 test by ELISA method. I am/ We are aware that this test is only for screening purpose and not confirmatory for HIV-AIDS. I/We understood that the Company reserves the right to accept, decline or offer alternate terms on this application.

In order to enable the Company to assess the risk under this application and any time thereafter, I/ We hereby, authorize the past and present employers(s)/ business associates/ medical practitioner/ hospital and medical source/ any life and non-life insurance company/or organisation or Life Insurance Association's medical register to release to the Company and the Company to release to any medical source/ any life and non-life insurance company/or Life Insurance Association or medical register, such details and provide the records of employment/business or other details as may be considered relevant. Information about me/ us may be collected and used by ICICI Prudential Life Insurance Co. Ltd. for the purpose of providing/ offering me/ us promotional material relating to any products and services. I/ We hereby agree that a waiting period as stated in the guidelines and applicable as per the product type, shall be applicable after revival of the policy. I/ We also understand that the terms and conditions including the premium and the benefits payable under the Policy are subject to variation in accordance with the applicable laws. This form shall be a part of my/ our Life/ Health insurance policy contract.

Signature/ thumb impression of the Life Assured	Signature/ thumb impression of the Policyholder (if different from the Life Assured)

Applicable when the Policyholder is illiterate or suffering from disability due to which his/ her capacity for writing is restricted or where the Policyholder has signed in a vernacular language. Note: The statement below must be witnessed by someone other than the advisor/ employee of the Company.

I/ We verify that the contents of the this form have been read over and clearly explained to me/ us and I/We have fully understood them. I/We further certify that the replies in this form have been recorded as per the information provided by me/ us.

Full name of witness/ person filling the form _____ (Relation with Policyholder) _____

Signature of Witness/ person filling the form	Signature/ thumb impression of the Life Assured/ Policyholder signing in a vernacular language)	Date: D D M M Y Y Y Y Place: _____

COMP/DOC/May/2022/25/0161