

## Declaration of State of Health Form

Name of Life to be insured: \_\_\_\_\_

Contract Number: \_\_\_\_\_ Present Occupation: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gain or Loss in past year: \_\_\_\_\_

Personal Physician: \_\_\_\_\_  
(Name and Address)**Please answer with 'YES' or 'NO' as applicable**

|  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Are you now in good health and entirely free from any mental or physical impairments or deformities?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever suffered or do you now suffer from:   |                          |                          |
| a) diseases of the circulatory system (e.g. heart trouble, rheumatic fever, high blood pressure, diseases of the arteries and veins)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b) diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c) diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d) diseases of the gastro-intestinal system (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B or other disorders of the liver, disorders of the gall bladder)?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| e) diseases of the nervous system or mental disorders (e.g. epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| f) diabetes, cancer, or any diseases of the blood, glands, spleen, ears, eyes or skin?   | <input type="checkbox"/> | <input type="checkbox"/> |
| g) unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhoea, unexplained infections or swollen glands?   | <input type="checkbox"/> | <input type="checkbox"/> |
| h) any other diseases or ailments not mentioned above?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had or been advised to undergo hospital treatment or surgery in the last one year?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you 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 in the last one year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you consulted a physician for any reason, including routine examinations and blood tests, or have you received any blood transfusions within the last one year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (If you answered "yes" to any of the above questions, please give complete details (including dates, duration and treatment, names and addresses of physicians) on the back of this form with your signature.) |                          |                          |
| 6. Has any proposal for life assurance been declined or postponed or been accepted with an extra premium in the last one year?   | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby declare that the foregoing statements and answers are full, complete and true. I agree that they shall be the basis of revival of my above contract of assurance and the Reliance Nippon Life Insurance Company shall not be liable for any claim on account of illness, injury, or death, the cause of which was known prior to approval of my request for revival of the contract of assurance and withheld or concealed in the above statements. I authorize any physician, nurse, hospital official or employee to disclose to the Reliance Nippon Life Insurance Company any and all information regarding my medical history.

Place: \_\_\_\_\_

Date:        

Signature of Life to be insured \_\_\_\_\_

Name of witness \_\_\_\_\_

Address of witness \_\_\_\_\_

Signature of Witness \_\_\_\_\_

If signature is in vernacular, please complete the following declaration: I have explained the contents of this form to the life to be insured and endeavored to ensure that the contents have been fully understood. I have accurately recorded the responses to the information sought in the form and I have read the responses back and confirmed that they are correct.

Name of Declarant \_\_\_\_\_

Address of Declarant \_\_\_\_\_

Signature of Declarant \_\_\_\_\_

Reliance Nippon Life Insurance Company Limited (formerly known as Reliance Life Insurance Company Limited). IRDAI Registration No: 121. Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra 400710. For more information or any grievance, 1. Call us between 9am to 6pm, Monday to Saturday on our Toll Free Number 1800 102 1010 or 2. Visit us at [www.reliancenipponlife.com](http://www.reliancenipponlife.com) or 3. Email us at: [rnlife.customerservice@relianceeda.com](mailto:rnlife.customerservice@relianceeda.com). Trade logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited & Nippon Life Insurance Company and used by Reliance Nippon Life Insurance Company Limited under license.

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