RELIANCE
Life Insurance

Application No.

(To be enclosed with the main proposal form)

Annexure to Reliance Health Insurance Proposal Form for covering family members under the same policy

(Separate Annexure to be filled in for each dependent family member) **FOR OFFICE USE ONLY** Occupation Code

1. NAME OF DEPENDENT MEMBER

Full Name (Mr./Ms.)

Date of Birth: D D M M Y Y Y Y **Age** **Gender:** ☐ Male ☐ Female **Annual income**

Marital Status: ☐ Single ☐ Married ☐ Widow(er) ☐ Divorcee

Relationship with Primary Insured: ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Child 4 ☐ Mother ☐ Father ☐ Mother-in-Law ☐ Father-in-Law
(Child cover will be solicited for eldest four eligible children)

Nationality

2. DETAIL OF DEPENDENT MEMBER

A. **Occupation:** ☐ Business ☐ Service ☐ Professional ☐ Retired ☐ Farmer ☐ Student ☐ Housewife ☐ Salaried ☐ Labourer ☐ Unemployed ☐ Others
Exact Nature of Duties

B. **For Age Proof please attach any one:** a. School Cert./Transfer Cert./Mark Sheet b. Baptism Cert. c. Marriage Cert. d. Employer Cert. e. Valid Passport f. Defence ID Card g. Aadhar Card h. Govt.Pension Orders i. Driving Licence j. Municipal Birth Certificate k. PAN Card l. Others

C. **Educational Qualification (dependent):** ☐ Post Graduate & above ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ 10th Pass ☐ Below 10th ☐ Uneducated ☐ Others

D. **For Child 1 to Child 4 up to 5 Years:** Reliance Care For You Advantage Plan / Reliance Easy Care Fixed Benefits Health Plan_Health declaration form to be attached.

3. DETAILS OF INSURED'S MEDICAL HISTORY FOR PRE-EXISTING DISEASE/ILLNESS/INJURY/CONDITION ☐ Yes ☐ No

Name and details of Disease / Injury / treatment	Duration of ailment etc.	Month & Year when first symptoms appeared / diagnosed / treated	Name of the consulting Doctor / Hospital /Nursing Home who / where attending to the ailments

4. DETAILS OF INSURANCE COVER HELD OR APPLIED FOR IN THE FORM OF CRITICAL ILLNESS / SURGICAL BENEFIT / HOSPITALIZATION / DEFINED BENEFIT AND / OR ANY OTHER HEALTH INSURANCE POLICY(S) / LIFE INSURANCE POLICY(S) ☐ Yes ☐ No

Name of the Insurance Company	Sum Insured	Policy No.	Product Name	Period of Insurance From To	Claim Received/ Receivable/ Repudiated	Claim Date	Treatment Details	Status
								☐ InForce ☐ Decline ☐ Postpone ☐ Rejected ☐ Rated Up ☐ Lapsed ☐ Applied

**Note: Please attach necessary proof (copy of Policy Document orPremium Receipt) stating the details of the insurance company with whom you have the insurance policy.

Are the dependent members (Child1 to Child 4) staying with the Primary Insured? ☐ Yes ☐ No
If No, whom is the child / children staying with? ☐ Hostel ☐ Maternal / ☐ Paternal Grandparents ☐ Others

5. LIFE STYLE & PERSONAL MEDICAL HISTORY QUESTIONS PERTANING TO THE PRIMARY INSURED: (If the answer is "yes" to any of the below questions, please provide details in the space provided below or in a separate sheet and attach treatment documents wherever applicable)

A	Is your occupation associated with any specific hazard?(chemical factory,mines, explosives,radiation,corrosive chemicals etc.) and /or Do you take part in activities or have hobbies that could be dangerous in any way? eg. Working at heights, underground or offshore, or employed in the armed, para military, police or special commando forces, using explosives, flying other than as a fare-paying passenger, diving, mountaineering, skiing or any other dangerous activity?	☐Y ☐N
B	Do you consume or have ever consumed Tobacco, Alcohol or any narcotics? if yes, please give the following details	☐Y ☐N
C	Have you ever suffered from drug or alcohol addiction or being advised by a Doctor to reduce or stop your alcohol/ tobaco/ drugs Narcotics/ consumption?	☐Y ☐N
D	Height in cms / Weight in Kgs Is there any weight change in the past 12 Months Gain Lost Reason:	☐Y ☐N
E	Do you have any physical deformity / handicap and / or any congenital defect / abnormality	☐Y ☐N
F	In the last 3 years have you ever been hospitalised or advised to undergone any tests, investigation, surgery?	☐Y ☐N
G	Are you under regular medical followup or on any medication for any chronic disease?	☐Y ☐N
H	Have you ever availed leave for more than 5 days on medical grounds in the last 2 years and / or have you been incapable of working / attending the school during last 2 years ?	☐Y ☐N

Details for B:

Substance Consumed	Consumed As	Quantity per day	No. of Years
Tobacco / Alcohol / any narcotics / Other subtances	**Tobacco -** Cigar / Cigarette / Beedi / Gutka / Others-specify **Alcohol (Glasses/Pegs) -** Beer / Wine / Hard Liquor / Others-specify		

I	Have you ever suffered or are suffering from any of the following?	☐Y ☐N
	1. Heart attack, angina, chest pain, rheumatic fever, murmur, heart valve disorder, irregular or fast heart rate, coronary artery disease, high blood pressure, high cholesterol or any disease or disorder of the heart or the blood vessels?	☐Y ☐N
	2. Respiratory system, chest or breathing discomfort, lung conditions, asthma, bronchitis, pneumonia, persistent cough, tuberculosis, pneumothorax, nasal bleeding, nasal polyps, sinusitis?	☐Y ☐N
	3. Albumin, protein, blood, sugar or pus In urine, kidney stones, urinary tract infection, prostate problem, incontinence or any disease or disorder of the kidney, bladder or genitourinary system?	☐Y ☐N
	4. Digestive system, liver, gallbladder, stomach, pancreas, Intestines, hepatitis, cirrhosis, stones, hernia, gastritis, ulcer, gastric / intestinal polyp, piles / haemorrhoids, fistula, chronic diarrhoea, irritable bowel disease, rectal bleeding?	☐Y ☐N
	5. Brain, mental or nervous system disorder, fits, epilepsy, paralysis, stroke,parkinsonism, multiple sclerosis, weakness of limb, numbness, poliomyelitis, migraine, prolonged headache, toss of balance, dizziness, fainting spells, anxiety or depression?	☐Y ☐N
	6. Diabetes, thyroid gland, or any disease or disorder of the endocrine system?	☐Y ☐N
	7. Cancer, tumour, cysts or any other growths, have you ever been referred to an oncologist or cancer hospital or any investigation or treatment?	☐Y ☐N
	8. Gout, arthritis, slipped-disc, persistent back / neck pain, osteoporosis, Systemic Lupus Erythematosus (SLE) or any disease or disorder of the spine, bones, limbs, joints, muscles or connective tissues?	☐Y ☐N
	9. Ears, throat, eyes or other physical disability or condition affecting hearing, speech or sight, otitis media, ear discharge, tonsils, cataracts, glaucoma, detached retina	☐Y ☐N
	10. Were you or your spouse or your children ever tested positive for hepatitis B or C, HIV / AIDS or any other sexually transmitted disease?	☐Y ☐N
	11. Leukemia, Anaemia or any other blood / lymphatic disorder	☐Y ☐N
	12. Any chronic skin problem, drug allergy or any other illness not listed above	☐Y ☐N
	13. Any other illness or impairement not mentioned above. If yes, please provide details	☐Y ☐N
	FOR FEMALES ONLY:	
	14. Have you /any of the insured ever had any gynecological disease requiring prolonged treatment or followup in the past	☐Y ☐N
	15. Are you Currently Pregnant ? If yes, Expected Date of Delivery ______	☐Y ☐N
	16. Have you been advised of or treated for any complications, inclusive of diabetes, glycosuria, hypertension, in your current or previous pregnancy? If yes, please give details	☐Y ☐N

If you have answered yes, to any of the above questions, please provide the details here

Question Number	**Complete Details required:** Please Provide details including health condition, date of diagnosis, treatment prescribed, name/address of doctor-if applicable

Signature of Insured ______ Date ______ Place ______

______
Signature of the Proposer / Primary Insured

6. FAMILY HISTORY OF DEPENDENT MEMBER

Family Member	Current Age	Healthy (Yes / No)	Name of Disease/Since when	If Deceased, age at dealth	Cause of Death
Father					
Mother					
Siblings					

Please attach separate sheet, if required

Mktg/Annexure - Health Insurance Form/Version 1.5/May 2014

ISO 9001:2008
CERTIFIED COMPANY

Reliance Life Insurance Company Limited (Reg. 121) Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra 400 710.
Corporate Office: 9th and 10th Floor, Bldg. No. 2, R-Tech Park, Nirlon Compound, Next to Hub Mall, Behind Oracle Bldg., Goregaon (E), Mumbai, Maharashtra 400 063.
For more information or any grievance, 1. Call us on our 24 X 7 Call Centre number - 3033 8181 (Local call charges apply) or our Toll Free Number 1800 300 08181 or 2. Visit us at www.reliancelife.com or 3. Email us at: rlife.customerservice@relianceada.com or 4. Fax: 022 3000 2222.
Insurance is the subject matter of the solicitation.
CIN: U66010MH2001PLC167089

As a part of CSR, Reliance Life Insurance is offering financial aid to Sudhir. Join us to secure the future for the Master's greatest fan. sms **SUDHIR** to **55454**