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?	☐	☐
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)?	☐	☐
b) diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia)?	☐	☐
c) diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)?	☐	☐
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)?	☐	☐
e) diseases of the nervous system or mental disorders (e.g. epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown)?	☐	☐
f) diabetes, cancer, or any diseases of the blood, glands, spleen, ears, eyes or skin?	☐	☐
g) unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhoea, unexplained infections or swollen glands?	☐	☐
h) any other diseases or ailments not mentioned above?	☐	☐
3. Have you had or been advised to undergo hospital treatment or surgery in the last one year?	☐	☐
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?	☐	☐
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?	☐	☐

(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?	☐	☐

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: D D M M Y Y Y Y

_____
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

CIN: U66010MH2001PLC167089

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