GENERALI Central
LIFE INSURANCE

Term rider Questionnaire

(To be completed by the Life Assured / Proposer / applying for Term Rider)

Name of the Life Assured:	
Application Number:	

Personal Health Record of Life Assured / Proposer:

Height (In cms) Weight (Kg)

In the past 6 months, has your body weight changed by more than 5 kg?

Gained ☐ Lost ☐ _____ in Kg

Visible Identification Marks, if any:

Sr. No	Answer the following	Tick the applicable	
A	**Are you suffering from or have you ever suffered from or sought advice or treatment or have been advised to underao investigation or treatment for :(Pl tick the relevant descriotion itaoolicabte)**	**Yes**	**No**
1.	Ulcer, Colitis, Gall Stones, Chronic Diarrhea, Piles, Fistula, Hepatitis A/B/C, Jaundice, Cirrhosis, or other Liver or Pancreas or Digestive Disorders?	☐	☐
2.	Chest Pain, Palpitation. Rheumatic Fever, Stroke. Heart Attack, Heart Murmur, Shortness of Breath, or Other Heart Disorders?	☐	☐
3.	Asthma. Bronchitis, Chronic Cough, Pneumonia, T.B., or any other respirator)' or lung disorders?	☐	☐
4.	Any skin disorder (E.g. dermatitis, eczema, Leprosy or psoriasis)?	☐	☐
5.	Cancer, Turner, Enlarged Glands or Enlarged Lymph Nodes?	☐	☐
6.	Thyroid Disorders or any other hormonal disorders?	☐	☐
7.	Anemia, Bleeding, hemophilia, thalassemia or Blood Disorders?	☐	☐
8.	Dizzy / Fainting Spells, Epilepsy, Multiple Sclerosis, Tremors, Numbness. Double Vision, Insomnia, Depression. Stress related problems, Paralysis, Nervous or Mental/Emotional Disorders?	☐	☐
9.	Urine. Kidney. Bladder, Reproductive Organ, Hydrocele or Prostrate Disorders?	☐	☐
10.	Arthritis, Gout. Hernia, Joint Pain, Muscle. Bone Fracture or disorders	☐	☐
11.	Disorders of the Eyes, Ears, Nose & Throat?	☐	☐
12.	High / Low Blood Pressure?	☐	☐
13.	Diabetes or sugar in the urine?	☐	☐
14.	Congenital or Hereditary disorders or diseases?	☐	☐
15.	Alcohol or drug abuse or dependency"	☐	☐
B.	**Apart from the medical conditions mentioned above have you in last five years**	**Yes**	**No**
1.	Suffered from any ailment; injury requiring treatment for more than a week	☐	☐
2.	Undergone or are currently undergoing or advised to undergo any form of medical treatment, investigation or test?	☐	☐
3.	Consulted any doctor or other health practitioner except for common cold/influenza lasting less than 7 days?	☐	☐
4.	Ever remained absent from your place of work on medical grounds for 7 consecutive days or more	☐	☐
C.	**Have you ever or are you currently suffering from any defect in sight, hearing or speech, or any physical mental disability or abnormality**	☐	☐
D.	**Have you or your spouse received medical advise, testing or treatment in connection with sexually transmitted disease or HIV infection, or suffered from prolonged weight loss, Diarrhoea, enlarged glands or have been advised to abstain from donating blood?**	☐	☐
E.	**Do you have any health symptoms or complaints for which a physician! homeopathy ayurvedic alternative medical advisor has been consulted or treatment received e.g. persistent fever, unexplained weight loss, loss of appetite, pain, swelling etc.?**	☐	☐
F.	**Name & Address of the family medical attendant:** _____		

If you have answered YES to any part of question, please complete the table below & attach relevant questionnaire:

Illness, Injury or tests	Date Commenced	Type of treatment	Duration of Illness/ Injury	Date of last symptoms	Current Condition	Full name and address of doctor or hospital (if any)

In case of major sickness/operation, the special questionnaire, hospital, doctor's report has to be submitted.

G.	Life Style (Tick the applicable)	Yes	No	If 'Yes', give details as below
1.	i) Do you consume any alcoholic drink? If Yes, indicate ☐ Beer ☐ Wine ☐ Hard liquor	☐	☐	Quantity Consumed per week (Glass / Peg) / Since when:
2.	Do you smoke cigarette or consume tobacco in any form?	☐	☐	Cigarettes (No.:) I tobacco: (mg) per day / Since when:
3.	Do you consume narcotics or any other drug not prescribed by a physician?	☐	☐	Name: Since when:
4.	Do you engage or have you any prospect or intention of engaging in aviation other than as a passenger on a regular airline or any other hazardous occupation, sports, hobbies or pursuits, eg rock climbing, car racing, bungee jumping, Para gliding etc?	☐	☐	If Yes, give details in relevant questionnaire
H.	**FOR FEMALE PROPOSER ONLY (Tick the applicable)**	**Yes**	**No**	**If 'Yes', give details as below**
1.	Are you pregnant at present?	☐	☐	Duration, in weeks:
2.	Date of last delivery	☐	☐	(DD/MM/YYYY):
3.	Details of any complications, miscarriage, or Caesarian section	☐	☐	If Yes, give details:
4.	Have you had or have any gynecological problem or been advised to have mammogram, biopsy or operation of the breasts, pelvis or any other gynecological tests?	☐	☐	If Yes, give details:
5.	Husband's Name (if married):	☐	☐	
6.	Husband's Occupation & Annual Income (if married):	☐	☐	
7.	Details of Husband's insurance (if married):	☐	☐	
8.	Maiden Name of Life to be Assured (if married):	☐	☐	

SECTION 3 AGREEMENT

1/ We hereby declare and agree that the above disclosures along with the Statements and the declaration made under the proposal will be the basis of the contract of assurance between me/us and Generali Central Life Insurance Company that if any statement is untrue or inaccurate or if any fact that might influence the terms of acceptance of this proposal is not disclosed, the contract shall be treated as absolutely null and void ab initio and all premiums so far paid in respect of this contract shall stand forfeited to the company.

Place : _____ Date : _____

_____
Signature of the Life Insured

Vernacular declaration: I have explained the contents of this form and have read out the responses to the Life Insured in his/her local language. He/she has confirmed that the contents are fully understood by him/her.

Name of the Declarant: _____

Address of the Declarant: _____

_____
Signature of the Declarant

Place: _____ Date: _____

_____
Signature of the Life Insured