



**6. CLAIM DETAILS IF ANY OF INSURED**

S.No. of Proposer	First Name of The Insured	Amount of Claim	Policy No.	Policy Period	Ailment for which amount claimed
1.					
2.					
3.					
4.					
5.					
6.					
7.					

**7. PLEASE ANSWER THE FOLLOWING QUESTIONS IN YES / NO**

PARTICULARS	SERIAL NO.OF PERSON IN PARA (1)						
	1	2	3	4	5	6	7
A. Are you in good health and free from physical and mental diseases or infirmity or major complaints ?							
B. Have you ever suffered from any of the following diseasee / illnesses. Please encircle the disease and write <b>Yes</b> otherwise write <b>No</b> .							
1 Any Neurological / mental or psychiatric diseases?							
2 slipped disc or other spinal disorder or paralysis of any kind or fainting episode, blackout, fit.							
3 High blood pressure, Heart diseases including ischaemic heart diseases, other circulatory disorders including rheumatic fever etc.							
4 Diseases of uterus, ovaries, breast or any other gynaecological disorder							
5 Fistula, Piles, Hernia, Varicose veins.							
6 Any disease of bones, joints Arthritis including rheumatic diseases etc.							
7 Any respiratory or allergic diseases							
8 Any dimness of vision or cataract etc.							
9 Any disease of ears or difficulty or interference with hearing etc.							
10 Any disorder of the stomach, ulcer, bowel or gall bladder, kidney etc.							
11 Cancer, malignant growth, boil, cyst or wound etc.							
12 Diabetes or any urinary diseases.							
13 Any cerebral or vascular strokes or similar disease.							
14 (a) Have you ever suffered from dental problems? YES/NO (b) If, yes, specify same. (c) When were you treated last for same.							
15 Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations.							
16 Any other complaint or tendency that may necessitate such consultation or treatment in the future							

**8. PLEASE GIVE DETAILS OF DISEASES/ ILLNESSES/INJURIES DEFORMITIES ETC DECLARED YES IN COLUMN NO. 7.**

S.No	Name of the insured person	Nature of illness / disease / injury	Date when first treated	Name & Address Of attending medical practitioners	Whether fully cured
1.					
2.					
3.					
4.					
5.					
6.					
7.					

**9. PLEASE STATE THE NAME OF PRE-EXISTING DISEASES / ILLNESS/ INJURIES SUFFERED / SUFFERS BY THE PROPOSER.**

S.No	First Name of the insured person	Name of disease / illness /injuries.	Remarks
1.			
2.			
3.			
4.			
5.			
6.			
7.			

**10. ARE THERE ANY ADDITIONAL FACTS EFFECTING THE PROPOSED INSURANCE WHICH SHOULD BE DISCLOSED TO THE INSURERS.**

S.No	First Name of the insured person	Remarks
1.		
2.		
3.		
4.		
5.		
6.		
7.		

**11. PLEASE GIVE THE DETAILS OF EXISTING MEDICLAIM POLICY.**

S.No	First Name of the insured person	Name of the Insurer	Policy no.	Sum Insured	Period	Remarks
1.						
2.						
3.						
4.						
5.						
6.						
7.						



**MEDICAL CERTIFICATE  
TO BE COMPLETED BY CONSULTING PHYSICIAN NOT BELOW MD.**

S.No.		1.	2.	3.	4.	5.	6.	7.
1.	Name of the Insured							
2.	Age							
3.	Any Past History of diseases / operations / investigation / accident / investigation with date and major complaints.							
4.	Details of past medication							
5.	Blood Pressure							
6.	Pulse							
7.	General Examination							
8.	Systemic Examination							
9.	ECG Report and observation							
10.	Blood / Urine Report							
11.	Present complaints investigation, if any.							
12.	Details of present medication.							
13.	Remarks.							

Signature of Proposer

NAME OF THE PROPOSER

Place:

Date:

Signature of Physician

Name, Address and Seal  
of physician with Registration No.