SELF DECLARATION FORM

(FORM TO BE DULY FILLED BY EACH APPLICANT ONLY IN DUPLICATE)

PERSONAL DETAILS

1. Name of the Insured : _____
2. Age (in completed years) : _____ 3. Date of birth : _____ Sex : _____
4. Address : _____

_____

5. Telephone No. : _____ E-mail ID : _____

Identification Document Details : (Photo ID Proof / Ration Card) _____

6. PERSONAL HISTORY :

PARTICULARS	YES / NO	DETAILS
A. Are You in good health and free from physical and mental diseases or infirmity of major complaints ?		
B. Have you ever suffered from any of the following diseases / illnesses. Please write Yes / No.		
1. Any Neurological / mental or related diseases ?		
2. Slipped disc or other spinal disorder or paralysis of any kind or fainting episode, blackout, fit.		
3. High blood pressure, palpitation, 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 etc.		
6. Any disease of bones, joints Arthritis including rheumatic diseases etc.		
7. Any respiratory diseases		
8. Any allergic diseases		
9. Any dimness of vision or cataract etc.		
10. Any Disease of ears of difficulty or interference with hearing etc.		
11. Any disorder of the stomach, ulcer, bowel or gall bladder, kidney etc.		
12. Cancer, malignant growth, boil, cyst or wound etc.		
13. Diabetes or any urinary diseases.		
14. Genital Disorder.		
15. Any cerebral or vascular strokes or sudden loss of consciousness or similar disease.		
16. Tuberculosis (TB)		
17. AIDS / HIV / related disorder etc.		
18. Congenital diseases (Since Birth)		
19. (a) Have you ever suffered from dental problems ? YES/NO (b) If, yes, specify same. (c) When were you treated last for same.		
20. Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations.		
21. Any other complaint or tendency that may necessitate such consultation or treatment in the future.		

(B) Have you Noticed Sudden decrease or increase in your weight in past six month **Yes / No**

(C) Have you visited a doctor / hospital / healthcare unit for evalution or treatment in recent past if yes, give details :

_____

_____

_____

Give Details of hospitalization (Attach Copy of discharge card and doctors consulation notes and investigations copy) :

_____

_____

_____

Past surgical details : Name of surgery or part operated _____

Date of operation : _____ Completely cured YES/NO. give details _____

_____

(Attach Copy discharge card and doctor's consultation notes and investigations copy)

I the Undersigned hereby declare that all the information given by me in this form is true and I understand that any of these details. If found untrue on correlation with my medical test or medical examination before or after issuance of policy will affect the coverage and payments of my health insurance benefit under this Mediclaim policy.

Name of applicant _____ Signature :

Date : Place :