

| 3.Education & Occupation Details | | Proposed Insured | | Proposer / 2 nd Proposed Insured | |
|--|---|------------------|---|---|-------------------------|
| Education | <input type="checkbox"/> Master & above <input type="checkbox"/> Graduation <input type="checkbox"/> Matriculation <input type="checkbox"/> Primary <input type="checkbox"/> None | | | <input type="checkbox"/> Master & above <input type="checkbox"/> Graduation <input type="checkbox"/> Matriculation <input type="checkbox"/> Primary <input type="checkbox"/> None | |
| Occupation | <input type="checkbox"/> Salaried <input type="checkbox"/> Business <input type="checkbox"/> Professional <input type="checkbox"/> Retired <input type="checkbox"/> Housewife <input type="checkbox"/> Unemployed <input type="checkbox"/> Agriculture <input type="checkbox"/> Student <input type="checkbox"/> Others | | | <input type="checkbox"/> Salaried <input type="checkbox"/> Business <input type="checkbox"/> Professional <input type="checkbox"/> Retired <input type="checkbox"/> Housewife <input type="checkbox"/> Unemployed <input type="checkbox"/> Agriculture <input type="checkbox"/> Student <input type="checkbox"/> Others | |
| Nature of Duties | | | | | |
| Employer's Name & Website/ Business details | | | | | |
| 4.KYC & AML Details | | Proposed Insured | | Proposer / 2 nd Proposed Insured | |
| Annual Income (in ₹) | | | | | |
| PAN | | | Form 60 | | Form 60 |
| GSTIN, if available | | | | | |
| Aadhaar No. | | | | | |
| Unique KYC Identifier code | | | | | |
| E-Insurance Account (eIA) No.* <small>*For opening new eIA please submit separate application form.</small> | | | | | |
| Age Proof | | | | | |
| Identity Proof | | | | | |
| Address Proof | | | | | |
| Income Proof | | | | | |
| Any other document/s | | | | | |
| 5.Nominee Details (Under Sec. 39 of Insurance Act 1938) To be filled where Proposed Insured and Proposer are same | | | Appointee Details (If Nominee is a minor) | | |
| Name & Surname | Nominee 1 | | Nominee 2 | | |
| Date of Birth | | | | | D D M M Y Y Y Y |
| Relationship to Insured | | | | | |
| % Share of Nomination | | | | | Relationship to Nominee |
| <small>*For additional nominees, provide details in separate sheet</small> | | | | | |
| 6.a) Product Details | | | | | |
| Product Name | | | | | |
| Option/Variant | | | | | |
| Product Type | <input type="checkbox"/> Unit Linked <input type="checkbox"/> Health <input type="checkbox"/> Non Unit Linked If Policy has to be backdated, mention date D D M M Y Y Y Y | | | | |
| | <input type="checkbox"/> Systematic Partial Withdrawal % of Fund Value <input type="checkbox"/> Extended Life Cover | | | | |
| | <input type="checkbox"/> Yearly <input type="checkbox"/> Half yearly <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly | | | | |
| Premium Amount | | | | | |
| Multiplier (For Unit Linked) | Premium Paying Term Benefit Term | | | | |
| Premium Frequency: | <input type="checkbox"/> Single <input type="checkbox"/> Yearly <input type="checkbox"/> Half yearly <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly | | | | |
| Premium Paid by | <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Proposer <input type="checkbox"/> Others (Third Party) | | | | |
| For Third Party Premium Payment | | | | | |
| Premium Payer's Name | | | | | |
| Relationship to Proposed Insured | | | | | |
| PAN | Aadhaar No. | | | | |
| Date of Birth | D D M M Y Y Y Y Age Gender Male Female | | | | |
| Address | PIN code | | | | |
| 6.b) For Pension Products (The annuity option selected shall be subject to the availability of the option on the date of vesting) | | | | | |
| Spouse Age (years) | Age at Vesting | Pension Option | Yearly Half yearly Quarterly Monthly | | |
| A) Annuity for life B) Annuity for Life with ROC C) Annuity for life with certain for Years D) Joint Life Last Survivor with 50% of annuity to spouse E) Joint Life Last Survivor with Roc on death of Last Survivor (100% of annuity to spouse) F) Joint Life Last Survivor with 100% of annuity to spouse | | | | | |
| 7.Bank Details | | | Premium Collection Details | | |
| Bank & Branch Name | | | Proposal Deposit | Cheque DD Credit/Debit Card Cash | |
| Account Number | | | Renewal Premium Payment Method | Cheque/Cash/DD NACH CCSI ADI | |
| IFSC Code | | | TOP UP Sum Assured | TOP UP Multiplier | TOP UP Premium Amt |
| Account Type | Current Savings NRE NRO | | | | |
| 8. Details of Policies held and/or applied for with Bajaj Allianz Life Insurance Company Limited and/or any other insurance Company, including details of declined, deferred or postponed proposals | | | | | |
| Has any of life and /Health Insurance or Critical Illness Insurance proposal or revival request been declined / postponed / dropped / rated up or accepted with modified terms? | | | Yes No | | |
| Annual premium paid by you for Insurance policies of your spouse / children / dependents? | | | ₹ | | |
| Please provide if any Life Insurance / medical Insurance cover held or currently applied with any of the Insurer? | | | Count of Total Policies Total SA (in ₹) | | |
| 9. Family Details | | | Proposed Insured | | |
| Is there a history of Diabetes, Cancer, High Blood Pressure, Heart or Kidney diseases, communicable diseases like Tuberculosis, Alcoholism, Mental Illness or suicide in your family? | | | Yes No | | |
| If Yes, how many family members were aged 50 or below at the time of diagnosis? | | | Yes No | | |



| Proposed Insured | | | | | 2 nd Proposed Insured | | | |
|------------------|-----|--------------------------|-----------------|----------------|----------------------------------|--------------------------|-----------------|----------------|
| Family Member | Age | Health Status (If Alive) | Age (When Died) | Cause of Death | Age | Health Status (If Alive) | Age (When Died) | Cause of Death |
| Father | | | | | | | | |
| Mother | | | | | | | | |
| Brothers | | | | | | | | |
| Sisters | | | | | | | | |
| Spouse | | | | | | | | |
| Children | | | | | | | | |

| 10. Life Style Details (Not Applicable for Immediate Annuity Proposals) | | | | | Proposed Insured | | | 2 nd Proposed Insured | | |
|---|---|---|-------------|--|------------------|-------------|--|----------------------------------|--|--|
| Height (cms) | Weight (kgs) | (W) (W) (W) | (H) (H) (H) | | (W) (W) (W) | (H) (H) (H) | | | | |
| Has your body weight changed in last 6 months? Cause of Weight Change | Same <input type="checkbox"/> Gained <input type="checkbox"/> kgs <input type="text"/> <input type="text"/> Lost <input type="checkbox"/> kgs <input type="text"/> <input type="text"/> | Same <input type="checkbox"/> Gained <input type="checkbox"/> kgs <input type="text"/> <input type="text"/> Lost <input type="checkbox"/> kgs <input type="text"/> <input type="text"/> | | | | | | | | |
| Do you plan to or were involved in any adventurous avocation such that but not limited to flying or travelling in a non-commercial aeroplane, automobile racing, horse riding, boat race, scuba diving? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | |
| Have you ever been convicted in the court of law or are there any criminal proceedings pending against you before a court? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | |
| Have you ever taken or undergone treatment for Narcotics or any addictive drug? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | |
| Have you consumed tobacco in any form during last 5 years? Used as (Name of the tobacco product) | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | |
| Quantity per day | | | | | | | | | | |
| If Quit, since when (MMYYYY) | M M Y Y Y Y | M M Y Y Y Y | | | | | | | | |
| Do you regularly consume alcohol? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | |
| Frequency of Consumption per week | | | | | | | | | | |
| Quantity of Consumption per week (ml.) | | | | | | | | | | |
| Has the consumption increased in last 6 months | Yes <input type="checkbox"/> EQUALLY <input type="checkbox"/> LESS <input type="checkbox"/> | Yes <input type="checkbox"/> EQUALLY <input type="checkbox"/> LESS <input type="checkbox"/> | | | | | | | | |

| 11. a) Declaration of Good Health | | | | | Proposed Insured | | 2 nd Proposed Insured | | |
|--|--|--|--|--|------------------|--|----------------------------------|--|--|
| Have you ever been diagnosed with, received any treatment or been referred for investigations related to: | | | | | | | | | |
| a) Chest Pain / Heart Attack / blood pressure / high cholesterol/ other cardiovascular disease or disorder? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| b) Undergone Angioplasty / Bypass surgery / any other Heart related surgery? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c) Diabetes / High blood sugar / Sugar in Urine / Other Endocrine system disorders such as hypothyroidism? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| d) Asthma / Tuberculosis / any other respiratory disorder? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| e) Stroke / paralysis / Epilepsy / Head Injury / Other Nervous disorder? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| f) Pancreatitis / Colitis / recurrent indigestion / ulcers / other Gastrointestinal disorders? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| g) Liver or gall bladder disorders / Jaundice / Hepatitis B or C? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| h) Genitourinary disorders related to Kidney, prostate or urinary system? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| i) Cancer / Tumor / Unusual growth or cyst of any kind? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| j) HIV infection or positive test of HIV for yourself / spouse / parents? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| k) Any blood disorders like Anemia, Thalassemia etc? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| l) Any Physical deformity or handicap, joints or muscular disorder, congenital defect or mental / psychiatric disorder? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| m) Any Injury / Surgery / Medical condition requiring Hospitalization or any medical condition / disorder not covered above? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |

| 11. b) Declaration of Good Health (Only For Females) | | | | | Proposed Insured | | 2 nd Proposed Insured | | |
|--|--|--|--|--|------------------|--|----------------------------------|--|--|
| a) Are you pregnant or undergone miscarriage or ectopic pregnancy or abortion in last 3 months? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| b) Have you suffered / are suffering from or have undergone investigation or treatment for any gynecological complications such as disorders of Cervix, uterus, ovaries, breast , breast lump, cyst etc. | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c) Total life insurance coverage on husband sum assure _____ Annual income of husband ₹ _____ | | | | | | | | | |

Question: If the answers to any of the questions in section 11 are "YES", please fill full particulars with details such as medical history, diagnosis, when it happened, treatment taken, names of medications, tests done, results of tests as annexed to this. Answers

| 12. Declaration Under Income Tax (11 th Amendment) Rules, 2015 for Premium Payer | | |
|---|--|--|
| Question | Answer | If there is any Yes, please provide following details along with the attested photocopy of the passport and/or the TIN Certificate/ proof. |
| Are you resident of any country outside India? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Name of Country: Address: |
| Are you a Tax Resident of a country (or countries) outside India (Country in which you are taxed because of your Residence/ Service/ Trade/ Business etc) | Yes <input type="checkbox"/> No <input type="checkbox"/> | TIN/Functional Equivalent No. TIN /Functional Equivalent No. Issuing Country (or Countries) Name: |
| Are you holding Telephone Number in Jurisdiction outside India | Yes <input type="checkbox"/> No <input type="checkbox"/> | Mobile No. Landline No. with ISD Code: |
| Have you given standing instructions (other than with respect to a depository account) to transfer funds to an account maintained in a jurisdiction outside India | Yes <input type="checkbox"/> No <input type="checkbox"/> | Provide Details: |
| Have you executed currently effective power of attorney or signatory authority granted to a person with an address in a jurisdiction outside India | Yes <input type="checkbox"/> No <input type="checkbox"/> | Name, Address & Contact No of the person whom power of attorney or signatory authority granted: |
| Have you given a "hold mail" instruction or "in-care-of" address in a jurisdiction outside India | Yes <input type="checkbox"/> No <input type="checkbox"/> | Provide Details: |

I declare that where required by domestic or overseas regulators and/or tax authorities, I consent and agree that Bajaj Allianz Life Insurance Company Limited may withhold from my policy account(s) such amount as may be required according to applicable laws, regulations and directives. I undertake to inform Bajaj Allianz Life Insurance Company Limited if there is a change in response to any of the questions above or to my nationality or residential status. I hereby declare that the information disclosed above is true, accurate and complete to the best of my knowledge and nothing material has been concealed or misrepresented

Self-Certification: To be filled only if: If your place of Birth or current residence or Tax residence is in a place outside India and Tax Identification Number (TIN) or Functional equivalent is not available Or In case you are declaring US person status as "no" but your country of birth is US, please provide document evidencing relating to relinquishment of US citizenship. if not available provide reasons for not having relinquishment certificate

I confirm that I am neither a US person nor resident for Tax purpose in any other country other than India, though one or more parameters in Part I suggest my relation with any country outside India. Therefore, I am providing the following document as proof of my citizenship and tax residency in India. Submission of a copy of Passport is mandatory.

Details of Document proof submitted: Passport ☐ Election Id card ☐ PAN card ☐ Driving Licence ☐ Latest ITR ☐ Aadhar Card ☐ Other Govt. issued id card

13. Declaration

- i) I/We hereby declare and agree that:-
- a) I/We have read the application/the same was interpreted to me/us by the person filling the Proposal Form whose name is mentioned herein below, and the answers entered in the application are mine / ours;
- b) I/We hereby certify that I have signed on the Proposal form after fully understanding the content and purport of the nature of the information asked for in this Proposal Form and confirm that each of the above answers is full, complete, and true to the best of my knowledge and nothing has been concealed and suppressed or declared false. I/We understand that Bajaj Allianz Life Insurance Company Ltd. (hereafter called the company) believing on the answers, will rely and act on them in utmost good faith, without verification or confirmation of any of my answers.
- c) Such application shall not be considered as effected by reason of any money paid or settlement made in payment of or on account of any premium paid, until this application is received by the Company and is finally approved by an authorized officer of the Company during my/our lifetime;
- d) Any personal information collected or held by the Company (whether contained in the this application or otherwise obtained) may be held, used and disclosed by the Company to reinsurance companies, claims investigation companies for doing claim analysis.
- ii) I/We hereby irrevocably authorize:-
- a) any organization, institution or individual that has any record of knowledge of my /the insured's health and medical history or any treatment or advise that has been or may hereafter be consulted or other personal information to disclose to the Company such information and such information shall only be used to decide on the terms of acceptance of this proposal or any claim arising out of the policy of insurance issued in accordance with this proposal. This authorization shall bind my/the insured successors and usages and remain valid notwithstanding my/ the insured's death or incapacity in so far as legally possible.
- iii) And I/We further agree that if after the date of submission of the proposal but before the communication to me/us of issuance of the First Premium Receipt on acceptance of proposal
- a) any change in my/insured occupation or any adverse circumstances connected with my/insured financial position or the general health of myself/insured or that of any members of my family, occurs or
- b) if a proposal for assurance or any application for revival of a policy on my life made to any office of the Company or any other Company has been withdrawn or dropped, deferred or accepted at an increased premium or subject to a lien or on terms other than as proposed I/we shall forthwith intimate the same to the company in writing to reconsider the terms of acceptance of assurance. In the case of fraud or misrepresentation by me, I/We understand that action will be taken or the policy will be cancelled in accordance with the provisions of Section 45 of the Insurance Act, 1938, as amended from time to time
- iv) Notwithstanding my registration with the NCPR or any Telecom Service Provider under Fully/Partially blocked category, I hereby consent to and authorize Bajaj Allianz Life Insurance Company Limited (hereinafter referred to as Company) to call or send SMS on the telephone number mentioned in this proposal form or any other telephone number as may be provided to the Company by me or contact me, through its representatives, for any matter (including ascertaining of feedback) relating to this proposal for insurance or any matter concerning the policy of insurance which may be issued pursuant to this proposal for insurance. I further authorize the Company to mail all service related communications to the email id as mentioned in the application form (applicable only if email id provided).
- v) I/ we declare that money used by me/ us to pay the premium/ s under the policy is acquired by legal means and confirms to the AML guidelines as they are updated from time to time.
- vi) I hereby provide my consent in accordance with Aadhaar Act, 2016, and regulations made there under for (a) collecting, storing and usage (b) validating / authenticating and (c) updating my Aadhaar number.

14. Signature

(Please do not sign on blank Proposal)

| | | | |
|---|--|--------------|---|
| Signature or thumb impression of Proposed Insured | Signature or thumb impression of 2 nd Proposed Insured/Proposer | Place: | |
| | | Date: | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Name & Address of the Witness | Signature of Witness | Witness Date | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

Vernacular Declaration: If signature of Proposer is in other than English Language.

"I hereby declare that I have fully explained the above questions to the proposer and I have truthfully recorded the answers given by the proposer."

Name of the Declaring: _____ Signature: _____ Address of the Declarant: _____

In case the Proposer is illiterate, his/her thumb impression should be attested by a person of standing whose identity can easily be established, but unconnected with the insurer and this declaration should be made by him. "I hereby declare that I have fully explained the above questions and contents of the proposal form to the proposer in _____ language, and that the proposer has affixed the thumb impression above after fully understanding the contents thereof."

Name of the Declaring: _____ Signature: _____ Address of the Declarant: _____

"I certify that the contents of the form and documents have been fully explained to me by (Name, Designation, and occupation) Mr. / Mrs.: _____ and I have understood the significance of the proposed contract.

Vernacular declaration _____ Signature or thumb impression of the person whose life is proposed to be assured: _____

Customer's Preferred Language
☐ ENGLISH ☐ Other Language _____

Signature or thumb impression

15. Insurance Consultant / Sales Intermediary-Details & Report

| | | | | | |
|---|----------------------|--|----------------------|-------------------------------|----------------------|
| Name & Surname of Proposed Insured | | Year <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> | | KYC / AML Documents Collected | |
| How long you have known Proposed Insured? | | Yes <input type="checkbox"/> No <input type="checkbox"/> | | As Identity Proof | |
| Is Proposed Insured immediate relative of IC or of BALIC employee? | | | | As Address Proof | |
| Proposed Insured Occupation & Income details | | | | As Age Proof | |
| Is Proposed Insured physically handicapped or having any adverse feature? | | If Yes, please provide details | | Any other documents | |
| Any other risk associated with Occupation, Sports Pursuit, Financial/ Social Position or Personal Habits of Life to be Assured/ Annuitant that could affect the risk in the Insurance Proposal: _____ | | | | | |
| FSC/IC Code | <input type="text"/> | Lead by code | <input type="text"/> | | |
| FSC/IC Name | <input type="text"/> | Sub id-code | <input type="text"/> | Relationship ref. code | <input type="text"/> |
| SP name | <input type="text"/> | SP code | <input type="text"/> | Emp code | <input type="text"/> |

On the basis of my independent inquiries, I certify that the particulars of the applicant are the same as stated in the proposal form. I state that the proposal has been filled up by the proposer/ person authorized by the proposer after fully understanding the nature of the questions in the proposal form and importance of disclosing all material information that has been explained by me to the proposer. I have also explained the features and benefits of the product plan to the applicant vide Benefit Illustration No. _____, if any, before the applicant consented to it. I also confirm that I have not induced or coerced the applicant / life assured have responded in their free volition. To the best of my knowledge the applicant has not applied for life insurance through any other agent other than indicated in the proposal form. I recommend this proposal for insurance. I confirm having verified the identity and address of the customers and proofs submitted for the same.

Signed by: ☐ FSC/IC ☐ Designated Employee in case of Brokers ☐ Specified Person in case of Corporate Agents ☐ MI Agent ☐ Employee in case of Direct Business ☐ Specified Person for others

Signature

Place: _____

Date:

SECTION 41 of the Insurance Act 1938: Section 41 of the Insurance Act 2015 as amended from time to time shall be applicable to your policy. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer. Any person making default in complying with the provision of the section shall be punishable with a fine that may extend up to ten lakh rupees.

SECTION 45 of the Insurance Act 1938: No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later. A policy of life insurance may be called in question at any time within three years from the date of policy, on the ground of fraud: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision is based. No insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer. Provided that in case of fraud, the onus of disproving lies upon the beneficiaries, in case the policyholder is not alive. A policy of life insurance may be called in question at any time within three years from the date of policy, on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived or rider issued: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision to repudiate the policy of life insurance is based: Provided further that in case of repudiation of the policy on the ground of mis-statement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured within a period of ninety days from the date of such repudiation. Nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal. For complete details of the section, please refer Section 45 of the Insurance Act, 1938, as amended from time to time.

***FUND NAMES AND SFIN:** LIQUID FUND: ULIF02510/07/06LIQUIDFUND116; BOND FUND: ULIF02610/07/06BONDFUND116; PURE STOCK FUND: ULIF02721/07/06PURESTKFUN116; EQUITY INDEX FUND II: ULIF03024/07/06EQTINDX02116; ASSET ALLOCATION FUND: ULIF04528/09/07ASSETALLO116; EQUITY GROWTH FUND II: ULIF05106/01/10EQTGROW02116; ACCELERATOR MID CAP FUND II: ULIF05206/01/10ACCMIDCA02116; BLUE CHIP EQUITY FUND: ULIF06026/10/10BLUECHIP02116; ASSURED RETURN FUND: ULIF06127/01/11ASSRDRETRN116; GUARANTEED BOND FUND: ULIF06322/09/11GTBONDFND116; PENSION BUILDER FUND: ULIF06908/02/13PENSIONBU116; PURE STOCK FUND II: ULIF07709/01/2017PURSTKFUN2116.

Glossary of all full form of riders:- WOP (Waiver of Premium); ADB (Accidental Death Benefit); APTPDB (Accidental Permanent Total/Partial Disability Benefit); FIB (Family Income Benefit); C.I. (Critical Illness)