

**Proposed Insured**

**2<sup>nd</sup> 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	61	HEALTHY	NA	NA				
Mother	56	HEALTHY	NA	NA				
Brothers	28	HEALTHY	NA	NA				
Sisters								
Spouse								
Children								

**10. Life Style Details (Not Applicable for Immediate Annuity Proposals)**

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Height (cms)	Weight (kgs)	0 9 0	1 8 0	(W) (W) (W)	(H) (H) (H)
Has your body weight changed in last 6 months? Cause of Weight Change		Same <input checked="" type="checkbox"/> Gained <input type="checkbox"/> kgs <input type="checkbox"/> <input type="checkbox"/> Lost <input type="checkbox"/> kgs <input type="checkbox"/>	Same <input type="checkbox"/> Gained <input type="checkbox"/> kgs <input type="checkbox"/> <input type="checkbox"/> Lost <input type="checkbox"/> kgs <input type="checkbox"/>		
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 checked="" 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 checked="" 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 checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Have you consumed tobacco in any form during last 5 years?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Used as (Name of the tobacco product)					
Quantity per day		M M Y Y Y Y	M M Y Y Y Y		
If Quit, since when (MMYYYY)					
Do you regularly consume alcohol?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	NOT APPLICABLE	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"/> EQUALY <input type="checkbox"/> LESS <input type="checkbox"/>	Yes <input type="checkbox"/> EQUALY <input type="checkbox"/> LESS <input type="checkbox"/>		

**11. a) Declaration of Good Health**

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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?
- b) Undergone Angioplasty / Bypass surgery / any other Heart related surgery?
- c) Diabetes / High blood sugar / Sugar in Urine / Other Endocrine system disorders such as hypothyroidism?
- d) Asthma / Tuberculosis / any other respiratory disorder?
- e) Stroke / paralysis / Epilepsy / Head Injury / Other Nervous disorder?
- f) Pancreatitis / Colitis / recurrent indigestion / ulcers / other Gastrointestinal disorders?
- g) Liver or gall bladder disorders / Jaundice / Hepatitis B or C?
- h) Genitourinary disorders related to Kidney, prostate or urinary system?
- i) Cancer / Tumor / Unusual growth or cyst of any kind?
- j) HIV infection or positive test of HIV for yourself / spouse / parents?
- k) Any blood disorders like Anemia, Thalassemia etc?
- l) Any Physical deformity or handicap, joints or muscular disorder, congenital defect or mental / psychiatric disorder?
- m) Any Injury / Surgery / Medical condition requiring Hospitalization or any medical condition / disorder not covered above?

Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**11. b) Declaration of Good Health (Only For Females)**

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- a) Are you pregnant or undergone miscarriage or ectopic pregnancy or abortion in last 3 months?
- 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"/>
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<sup>th</sup> 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 checked="" 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 checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/>	Mobile No. +91 - 909045020 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 checked="" 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 checked="" 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 checked="" 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 \_\_\_\_\_