Annexure 2

Form No.HI/DGH/2
(Major Insured other than Principal Insured)

Life Insurance Corporation of India,

(Personal Statement regarding health for Major Insured member
{other than principal Insured} under Health Plus policies)

Divisional Office_____ Branch Office _____ Policy Number _____

1	Full Name of the Principal Insured			
	Full Address			
1(a)	Name of the insured member			
			Occupation →	
2	Since the date of the commencement of the health cover on the policy		Answer 'Yes' or 'No'	If 'yes', give details of ailment, date & duration, doctor consulted, etc.
	a) Are you currently taking any medication or drugs, either prescribed or not prescribed by a doctor, or have you suffered any illness, disorder, disability or injury which has required any form of medical or specialized examination, consultation, hospitalization or surgery? b) Did you undergo any ECG, X-ray or screening, blood, Urine or stool examination? c) Do you have any proposal for life, medical, health, accident, disability cover, critical illness or any other health related insurance that has been postponed, declined or accepted on special terms? d) Is any proposal or an application for revival of a lapsed policy on your life under consideration at this or any other office of the Corporation?			
3	Are you at present in sound health?			
4	(For Revivals under Non-medical only) State your height (without shoes):_____cm and weight _____kgs			
5	**For Female lives only** Since the date of commencement of health cover under this policy a) Have you had periodical cycles regularly? b) Have you had any miscarriage? c) Are you pregnant now?			
	Date of Last menstruation →		Date of last delivery →	

I, _____ do hereby declare that the foregoing statements and answers are true and complete in every particular and agree and declare that these statements and this declaration along with earlier policy for insurance/proposal for insurance shall be the basis of the contract of assurance with the Life Insurance Corporation of India and that if any untrue averment be contained therein the said contract shall be absolutely null and void and all the moneys which have been paid in respect thereof shall stand forfeited to the Corporation.

Dated at _____on the _____day of _____20_____

Signature of the witness:_____
Occupation & Address:_____ Signature or Thumb Impression of the Insured member

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In case form is filled up/signed in a language different from that of the health declaration form:

Declaration by the person filling in the form:

(I hereby declare that I have fully explained the above questions to the Principal Insured in _____ language and I have truthfully recorded the answers given by him/her.)

Name and Address _____ _____
of the Declarant : _____ Signature or the Declarant

*** In case the Insured is Illiterate**

(The thumb impression should be attested by a person of standing whose identity can easily be established, but unconnected with the Corporation and this declaration should be made by him.)

I hereby declare that I have explained the contents of this form to the Principal Insured in ……..(language) and that I have read out to the Principal Insured and the answers to the questions are dictated by the principal Insured and that the insured has affixed his/her thumb impression to the form after fully understanding the contents there of.

Address of the declarant. Signature of the declarant.