

IndiaFirst Life Insurance Company Ltd



Name of Life To Be Assured / Proposer: _____

Requirement: **Question No. 18 to 28**

Application No.																			
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LIFE STYLE QUESTIONS AND PERSONAL MEDICAL HISTORY OF THE LIFE TO BE ASSURED (Please tick Yes or No to each question)

	Life to be Assured
18 Height in Cm <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> / Feet <input type="text"/> <input type="text"/> Inches: <input type="text"/> <input type="text"/> Weight in Kg: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
19 Have you taken part, or do you have plans to take part, in any hazardous activity such as ballooning, mountain cycling, motorbike racing, boxing, gliding, diving, horse riding, martial arts, motor racing, mountain climbing, parachuting, sailing, skiing, weight lifting, white water rafting, wrestling and / or flying other than as a fare paying passenger on a licensed service? (you must still answer YES and give details if you take part in a potentially hazardous activity which is not listed). If Yes, please provide details in the special questionnaire which your advisor will provide	<input type="checkbox"/> Yes <input type="checkbox"/> No
20 Are you currently or do you intend to live or travel outside of India for more than 6 months in a financial year? If yes, please provide full details of countries to be visited and purpose of visit and duration _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
21 Have you smoked or used any form of tobacco in the past 12 months? If Yes, please indicate in which form: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Beedi <input type="checkbox"/> Chew <input type="checkbox"/> Gutka Qty per day <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
22 Do you consume any form of alcohol? If yes, what type? <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Hard liquor Qty per week <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
23 Are you currently taking any medication or drugs, other than minor conditions, (e.g. colds and flu), either prescribed or not prescribed by a doctor, or have you suffered from any illness, disorder, disability or injury during the past 5 years which has required any form of medical or specialized examination (including chest x-rays, gynecological investigations, pap smear, or blood tests), consultation, hospitalization or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24 Do you have : congenital/birth defects, pain or problems in the back, spine, muscles or joint, arthritis, gout, severe injury or other physical disability and have you been incapable of working/attending the school during the last 2 years for more than 3 consecutive days or are you currently incapable of working/attending school? Please ignore normal pregnancy.	<input type="checkbox"/> Yes <input type="checkbox"/> No
25 Do you suffer from any medical ailments e.g.: diabetes, high blood pressure, cancer, respiratory disease (including asthma), Kidney or Liver Disease, Stroke, any blood disorder, Heart Problems, Hepatitis B or, Tuberculosis, Psychiatric Disorder, Depression, colitis or any other stomach problems, Thyroid disorders, Reproductive organs, HIV AIDS or a related infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26 Have you ever been advised/ had a surgery or any medical investigations like X-ray, CT scan, mammogram, pap smear etc?	<input type="checkbox"/> Yes <input type="checkbox"/> No
27 Have you ever suffered from drug / narcotics or alcohol addiction or been advised by a doctor to reduce your alcohol/ tobacco consumption?	<input type="checkbox"/> Yes <input type="checkbox"/> No
28 In the last 3 years, have you been treated, are currently undergoing or have been advised to treatment from a doctor or specialist or undergone any cardiological, radiological or pathological tests (excluding routine check- ups)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Life To Be Assured / Proposer

Place: _____

Date: _____

Signature of FA / CRO / BDM

Place: _____

Date: _____