

All entries should be filled in capital letters:

1. Name	<input type="text"/>
2. Date of Birth	<input type="text"/>
Age on next birth day	<input type="text"/>
Nature of proof of age	<input type="text"/>
Place of Birth	<input type="text"/>
3. PH Code	<input type="text"/>
4. Sum Assured	₹ <input type="text"/>
5. (a) Type of Policy	<input type="text"/>
(b) Term	<input type="text"/>
6. Age at Maturity	<input type="text"/>
7. BPO Pin code	<input type="text"/>
8. BPO Code	<input type="text"/>
9. BPO Name	<input type="text"/>
10. Division	<input type="text"/>
11. Region	<input type="text"/>
12. PAO Sub code	<input type="text"/>
13. Date of proposal	<input type="text"/>
14. Date of Declaration	<input type="text"/>

Policy No.

Type

Sum Assured (in ₹)

Proposer: - 1.
2.
3.

Total: _____

28. Has any of your proposals been earlier rejected or extra premium levied thereon by any insurer?
Give details.

29. Family history:

Has any of your family members (living or dead) suffered from any hereditary or infectious disease like Insanity/ Epilepsy/ Gout/ Asthma/ Tuberculosis/ HIV/ Cancer/Leprosy/ Diabetes etc.

(Note: The term family includes Mother, Father, Brothers & Sisters.)

30. (a) Are you at present in sound health? Yes No

(b) Have you ever suffered from any of the following diseases?

(i) Tuberculosis : Yes No

(ii) Cancer : Yes No

(iii) Paralysis : Yes No

(iv) Insanity : Yes No

(v) Any disease of heart and lungs : Yes No

(vi) Kidney disease : Yes No

(vii) Any disease of brain : Yes No

Yes No

No

(viii) Diabetes	:		
(ix) Hypertension	:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(x) HIV Positive	:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(xi) Hepatitis-B	:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(xii) Epilepsy	:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(xiii) Nervous disorder	:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(xiv) Liver	:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(xv) Leprosy	:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(xvi) Any physical deformity or handicap	:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(xvii) Any other serious disease	:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

(c) Have you availed of any kind of leave on medical ground or hospitalized during the last 3 years? If so, furnish the following information.

	<u>Kind of leave</u>	<u>Period of leave</u>	<u>Ailment</u>	<u>Name of Hospital</u>	<u>Period of Hospitalization</u>	
					<u>From</u>	<u>To</u>
1.						
2.						
3.						

(d) Particulars of the family doctor, if any: _____

For Female Proposers Only

31. (a) Marital status

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(b) No. of children

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(c) Date of last delivery

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(d) If pregnant, then expected month of delivery

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32. Mark of Identification (Two)

(a)

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(b)

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Signature of Appointee

For medical Cases only

I certify that the proposer has signed / put his/her thumb impression in my presence, after admitting that all the answers to question No 30 and onwards of form have been correctly recorded.

Signature or thumb impression of the proposed
NB- Signature or thumb impression should be affixed in
the presence of medical examiner

Signature of the medical examiner

Designation:
Seal:
Date:
Doctor's Code:

DECLARATION BY THE PROPOSER

I hereby declare that the foregoing statements and answers have been given by me after fully understanding the questions and the same are true and complete in all respects and that I have not withheld any information and I do hereby agree and declare that these statements and this declaration shall be the basis of the contract of assurance between me and the Department of Posts and that if any untrue averment be contained therein, the said contract shall be absolutely null and void and all moneys which shall have been paid in respect thereof shall stand forfeited to the Department.

Notwithstanding the provision of any law, usage, custom or convention for the time being in force prohibiting any doctor, hospital and / or employer from divulging any knowledge or information about me concerning my health or on the grounds of secrecy I, my heirs nominee, executors, administrators and assignees or any other persons or persons having interest of any kind whatsoever in the policy contract issued to me, hereby agree, that such authority, having such knowledge or information shall at any time be at liberty to divulge any such knowledge or information to the Department.

And I further agree that if after the date of the submission of the proposal but before the acceptance of the proposal, (i) any change in my occupation or any adverse circumstance connected with my financial position or the general health of myself or that of any member of my family occurs or (ii) if a proposal for assurance or an application for revival of a policy on my life made to any office of the Department has been withdrawn or dropped, deferred or declined or accepted at an increased premium or subject to a lien or a term other than as proposed, I shall forthwith intimate the same to the Department in writing to reconsider the terms of acceptance of assurance. Any omission on my part to do so shall render this assurance invalid and all moneys which shall have been paid in respect thereof forfeited to the Department.

- a) The contents of surrender table and instructions for admissibility of surrender value have been explained to me before taking policy and I abide by the same.
- b) Surrender of a policy is not admissible before completion of thirty six months of the policy and the amount deposited shall be forfeited if I surrender the policy without paying premiums for thirty six months.
- c) On surrender, the policy shall attract proportionate bonus on reduced sum assured up to the date for which premium has been paid. However, no bonus shall be payable before completion of 5 years of the policy.
- d) The discontinued policy shall not attract bonus with effect from the date from which the premium is discontinued.
- e) The reduced sum assured shall be calculated by multiplying the sum assured with the number of instalments paid and dividing the same with the total number of premiums to be paid.
- f) The surrender value shall be calculated by multiplying the sum of reduced sum assured plus the proportionate bonus, if any, with the surrender factor as applicable on the attained age on the date of surrender of the policy.

Signature of witness

Name _____ Occupation _____

Address _____

Signature/thumb impression of the person whose life is proposed to be assured

Note : If in this form the answers to the questions and / or signature of the proposer hereinabove are/is in vernacular then he/she should declare above his/her signature in his/her own handwriting that the replies are given after fully and properly understanding the same.

Declaration by the person filling in the form

Declarant's Name _____

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

Address _____

Signature of Agent or the person filling the proposal form

Date : _____

Declaration in case the proposer is illiterate

Note : In case the proposer is illiterate the thumb impression of the proposer should be attested by a person of standing whose identity can easily be established but unconnected with the Deptt. and this declaration should be made by him.

I hereby declare that I have explained the content of this form to the proposer in
..... (Language) which he/she easily understands and that the proposer has affixed the thumb impression above after fully understanding the contents there of

Declarant's Name

Signature

Address

Date

Confidential Report

This will consist of information not revealed in the proposal form. SDI/ ASP report is not only required for granting a policy but will also be required when claim arises, to check the correctness of data in proposal form. This will be completed by SDI/ ASP after proposal form is completed by proposer. Content of the report should not be discussed with the proposer or divulged to him.

(The form should be completed by SDI/ASP)

1. Are you related to the proposer? :

Yes	NO
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2. Are you aware of any financial/physical/mental situation concerning proposer which makes him unsuitable for consideration of his Insurance proposal? :

Yes	NO
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3. In case of any doubt, please visit the concerned police station and verify if the proponent was ever arrested/ convicted in the criminal case. If yes, give details. :

Yes	NO
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4. Has he signed proposal/Declaration form? :

Yes	NO
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5. Any other matter you would like to bring to the notice of Proposal accepting authority. :

Yes	NO
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6. Do you recommend the acceptance of the proposal? :

Yes	NO
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7. If not recommended, give reasons. :

Yes	NO
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8. Please confirm that :-
 - (1) Confidential report has been written by you after completion of proposal form by proposer. :

Confirmed	Not Confirmed
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 - (2) Confidential report has not been divulged to proposer/or discussed with him. :

Confirmed	Not Confirmed
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***Signature SDI/ASP
Full Name With Stamp***