pnb MetLife

Milkar life aage badhaein

Member Application No.:____________________________

PNB MetLife India Insurance Company Limited

Registered office: Unit No. 701, 702 & 703, 7th Floor, West Wing, Raheja Towers, 26/27 M G Road, Bangalore -560001, Karnataka. Insurance Regulatory and Development Authority of India Registration number 117. CI No. U66010KA2001PLC028883, Call us Toll-free at 1-800-425-6969, Website: www.pnbmetlife.com, Email: indiaservice@pnbmetlife.co.in or write to us at 1st Floor, Techniplex -1, Techniplex Complex, Off Veer Savarkar Flyover, Goregaon (West), Mumbai – 400062. Phone: +91-22-41790000, Fax: +91-22-41790203

DECLARATION OF GOOD HEALTH (Valid for 3 months from the signature date)

Important Instructions: 1. The form needs to be filled with single Ink. 2. In case of any corrections or overwriting, fresh form needs to be filled.

Policy Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Full Name of Life Insured: *(If Different from Policy Owner)*

☐☐

I wish to reinstate my above mentioned policy with PNB MetLife India Insurance Co. Ltd.

Marital Status: ☐ Married ☐ Unmarried ☐ Others(Specify) ____________________ Contact No.: ____________________

Email ID:____________________ Aadhaar No*.: ☒☒☒☒☒☒☒☒☐☐☐☐ *Only last 4 digits of Aadhaar No. to be mentioned

1. ALL QUESTIONS TO BE ANSWERED WITH REFERENCE TO LIFE INSURED

1. Education Qualification: ☐ Post Graduate and above ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ 10th Pass ☐ Illiterate ☐ Others (Specify)____________________

2. Has your Occupation changed from that at the time of issue of the Policy? ☐ Yes ☐ No (If yes, please mention the following details):____________________

3. What is your present Occupation? Is the occupation associated with any specific hazards ☐ Yes ☐ No (e.g. Mines, Explosives, Corrosive Chemicals, HTV Drivers, Security Guard, Armed Services, etc.). Current Occupation ____________________ *If yes, please provide details (Please complete the appropriate questionnaire in consultation with your Insurance Agent)*

4. Nationality : ☐ Indian ☐ Non-Resident Indian ☐ Person of Indian Origin ☐ Foreign National Country Name ____________________
(If Non-Resident Indian or People of Indian Origin or Foreign National, please mention the country you reside in the space provided above and complete NRI/PIO/Foreign National questionnaire)

2. PERSONAL DETAILS

Height in Cms_________ / or Ft_________ /Inches_________Weight in Kgs_________ / or Pounds_________

3. MEDICAL DETAILS

		Yes	No			Yes	No
1	High blood pressure, chest pain, angina, heart attack or any other disease of the heart or circulatory system? If Yes, please specify the details____________	☐	☐	2	Seizures, stroke, paralysis, epilepsy, Parkinson's, multiple sclerosis, other disorder of the brain or nervous system? If Yes, please specify the details______________	☐	☐
3	Tuberculosis, Asthma, Avian Flu, Bronchitis, Shortness of breath, or any other respiratory disorder? If Yes, please specify the details____________________	☐	☐	4	Cancer, tumor, cyst, leukemia, growth, lump or other malignancy? If Yes, please specify the details____________________	☐	☐
5	Any kidney, bladder disorder or prostate disease, blood/protein in urine? If Yes, please specify the details____________________	☐	☐	6	Ulcers or any stomach or intestinal disorder/Any disorder related to ear, nose and throat? If Yes, please specify the details____________________	☐	☐
7	Diabetes, thyroid or any other gland related disorders? If Yes, please specify the details____________________	☐	☐	8	Depression, stress, anxiety, attempt to suicide or any other psychological or emotional disorder or nervous breakdown or Mental illness or symptoms of the same? If Yes, please specify the details____________________	☐	☐
9	Any medical advice/counseling/treatment taken for HIV/AIDS or Hepatitis B/C or any Sexually Transmitted Disease? If Yes, please specify the details____________________	☐	☐	10	Have you consulted any doctor for any health concern for more than 4 days Undergone ECG, X-rays, Blood test or other tests or have been admitted/advised to be admitted to any hospital/clinic? If Yes, please specify the details_________	☐	☐
11	Do you have any physical/mental deformity / defect/Any Back, Arthritis, Joint or Bone Disorders or Skin Lesion? If Yes, please specify the details_____________	☐	☐	12	Has there been drastic weight loss or weight gain (> =5 kgs) in the past year? If Yes, please specify the details____________________	☐	☐
13	Have you undergone or been advised to undergo surgery of any kind or any major organ transplant?	☐	☐	14	Have you abstained from work for more than 7 days due to any illness, injury, disease or medical examination not specifically covered above? Please give details of the illness treatment /medication taken or being taken? If Yes, please specify the details____________________	☐	☐

QUESTION (15-17) TO BE ANSWERED BY FEMALE LIVES ONLY

		Yes	No
15	Are you pregnant now? (If yes, mention the duration of pregnancy and complications, if any, relating to pregnancy) ____________________	☐	☐
16	Have you undergone caesarian section, had any abortion or miscarriage? For each "Yes" provide details. ☐ In the last 3 months ☐ 3 to 6 months ☐ More than 6 months	☐	☐
17	Have you suffered from any disorder of the breast or reproductive organs? If yes, please provide details ____________________	☐	☐

For each "Yes" answer in Section 3 please identify the question and give full details, conditions, dates, duration and results. Give full names and addresses of Doctor/Hospital/clinic etc. (Do use an additional sheet, if required)

Question no .	Details

4. GENERAL DETAILS

		Yes	No
4.1	Has any proposal or application for reinstatement of a policy on your life made to any other Insurance Company ever been withdrawn or dropped, accepted with extra premium or lien, deferred or declined or accepted on terms other than proposed? If Yes, please give details____________________	☐	☐
4.2	Any change in nationality from the time you took the policy? If yes, please mention the following details : Country You Reside in ____________________	☐	☐
4.3	Do you consume any of the following substances-Tobacco/Alcohol/Narcotics/Drugs? If yes, please mention the following details : Substance consumed_______________ Quantity________ per day, Consuming from when_________________Number of Years________ Months_________ If stopped consuming, date month & year of stoppage D D M M Y Y Y Y	☐	☐
4.4	Any legal or criminal case pending/convicted? If yes, please give details____________________	☐	☐
4.5	Do you engage in professional sports (Automobile or Motor–Cycle Racing, Skin or Scuba Diving, Skydiving) If yes, please give details ____________________	☐	☐

REASON FOR NON-PAYMENT OF PREMIUM (Please tick only one)

I, _____ the Policy Owner of the above mentioned Policy could not pay premium within the time period provided in the policy, due to below mentioned reason:

☐ Non receipt of communication from the Company due to out of country/ remote place of residence/ change of contact details

☐ Could not operate and respond due to illness/ tragedy in immediate family

COVID-19 Exposure and Travel Declaration

1. Have you or your close family members travelled abroad in the past 21 days? Yes ☐ No ☐

2. Do you intend to travel abroad in next 3 months? Yes ☐ No ☐

3. Have you or any of your family members currently suffering/ or in the last 21 days suffered from fever, cough, sore throat, flu like symptoms or gastrointestinal symptoms. Yes ☐ No ☐

4. Have you or your family members have been tested positive for novel coronavirus or advised to be tested to rule out the diagnosis of the same? Yes ☐ No ☐

5. Have you or any of your family members have been served a notice of quarantine or come in close contact with anyone who has been quarantined? Yes ☐ No ☐

6. Does your occupation involve any duties where you need to be in close contact with COVID-19 diagnosed or quarantined patients? Yes ☐ No ☐

DECLARATION BY THE LIFE INSURED / POLICY OWNER

I, do hereby solemnly affirm and state that, all the answers given above are true & complete to the best of my knowledge and belief. I further affirm that, I would duly intimate PNB MetLife any material change in any of the critical factor impacting reinstatement of the policy on happening of such material change. I also understand and agree that, the risk under the lapsed policy does not commence till such time the application for reinstatement is accepted by PNB MetLife India by issuing a Renewal Premium Receipt.

_____ _____

Signature/ Left Thumb Impression of the Person Insured

Name of Person Insured: _____

Date: D D M M Y Y Y Y

Place:_____

Signature/ Left Thumb Impression of the Policy Owner

Name of Policy Owner: _____

Date: D D M M Y Y Y Y

Place:_____

Name of the Witness: _____ Address of Witness : _____

_____

Signature of the Witness (Witness should not be related to the Insured/Owner) Date: D D M M Y Y Y Y

TO BE FILLED IN BY PNB METLIFE SERVICE PERSONNEL: Have the Signatures of Life Assured / PO been verified with the signatures in application form? ☐ Yes ☐ No

Note - Policy Owner Signature verification is required in case Life Assured is a minor.

Declaration by the person filling in the form (In case the form is filled up / signed in a language different from that of the form / where thumb impression is affixed)

I hereby declare that I have fully explained the contents of this declaration form to the Life Insured/Policy Owner in the language understood by him/her. The same have been fully understood by him/her and the replies have been recorded as per the information provided by the Life Insured/Policy Owner and the replies have been read out to, fully understood by and confirmed by the Life Insured/Policy Owner.

Declarant's Name:_____ Address :_____

_____Pincode:_____

Signature of the Declarant

In case the Life Insured/Policy Owner is illiterate, a person of standing, unconnected with MetLife, but whose identity can easily be established, should give the following declaration after attesting left thumb impression of the Life Insured/Policy Onwer**

I hereby declare that I have explained the contents of this declaration in _____language to the Life Insured/Policy Owner. The same have been fully understood by him/her and replies have been recorded as per the information provided by the Life Insured/Policy Owner and the answers have been read out to and fully understood by and confirmed by the Applicant. The Life Insured/Policy Owner has affixed his/her left thumb impression in my presence.

_____ _____

Left Thumb Impression of the Life Insured /Owner
(Where the Life Insured is minor, the Legal Guardian should attach this form)

Left Thumb Impression of the Policy Owner
(If different from Life Insured)

Name of Declarant :_____ Address :_____ Pincode :_____