MEDICAL QUESTIONNAIRE

INSTRUCTIONS FOR FILLING IN THE FORM
▪ This form is to be filled by the life to be insured himself in **BLOCK LETTERS in** black or blue ink. ▪ Please tick √ a box where appropriate. ▪ Insurance is a contract of utmost good faith which requires the life to be insured to disclose all material facts. In case of any doubt as to whether a fact is material or not the fact should be disclosed. ▪ As the statements in this Questionnaire constitute warranties, complete and accurate information must be given. ▪ Any cancellation or alteration must be signed by the life to be insured. ▪ 'Company' shall mean Kotak Mahindra Life Insurance Company Ltd. ▪ Please strike out parts which are not applicable and write 'N.A.'. Strokes of the pen, dots and dashes will not be accepted as responses.

FOR OFFICE USE ONLY					
Inward No.:		**Date of receipt of declaration:**	DD	MM	YYYY
CRM Name:		**Branch code:**			
TO BE FILLED BY THE POLICYHOLDER					
Name of the Policyholder:					
Name of the product:					
Member ID:		**Policy Number:**			
Category (if applicable):		**Salary/Cover:**			

1. PARTICULARS OF LIFE TO BE INSURED						
Mr/Ms/Title	Surname	First name	Middle name			
Date of Birth	DD	MM	YYYY	Gender:	❑ Male	❑ Female
FATHER'S NAME						
Mr/Title	Surname	First name	Middle name			

2. PERSONAL DETAILS OF LIFE TO BE INSURED					
Tobacco Habits			**Consumption of alcohol**		
❑ Chewing Tobacco / Gutka ❑ Smoking	❑ Using Tobacco toothpaste ❑ None		❑ Yes ❑ No	(If **YES**, kindly give below details of alcohol consumption per day)	
Frequency of tobacco intake per day			Alcohol consumption per day (Units) *		
(* Number of units consumed - one unit is equivalent to half a pint of beer, one glass of wine or one measure of spirits)					
Height in Cms.			Weight in Kgs		
Marital Status :	❑ Single	❑ Married	❑ Divorced	❑ Widowed	

3. FAMILY HISTORY OF LIFE TO BE INSURED				
	Living		**Deceased**	
	Age(s)	State of Health	Age(s) at death	Cause of death
Father				
Mother				
Brothers				

Sisters				
Spouse				
Children				

Have the parents / brothers / sisters of the life to be insured suffered from or died of heart disease, stroke, high blood pressure, diabetes mellitus, any form of eye disease, cancer, kidney disease or paralysis, or any hereditary/familial disorders? If **YES**, kindly give details.	❑ Yes	❑ No
Have the parents / brothers / sisters / spouse / children of the life to be insured suffered from or died of any contagious diseases such as tuberculosis, hepatitis, AIDS / HIV etc.? If **YES**, kindly give details.	❑ Yes	❑ No

MEDICAL HISTORY OF THE LIFE TO BE INSURED			
4.	**DURING THE LAST THREE YEARS**		
a)	Has the life to be insured consulted a Medical Practitioner for any ailment /injury requiring treatment for more than 7 days?	❑ Yes	❑ No
b)	Has the life to be insured remained absent from his/her place of work for more than 7 days, on health grounds or claimed against his/her health insurance policies?	❑ Yes	❑ No
c)	Has the life to be insured undergone any cardiological / pathological or radiological tests, other than routine testing for insurance or employment?	❑ Yes	❑ No

5.	**DURING LIFETIME**		
a)	High or low blood pressure, rheumatic fever, chest pain, myocardial infarction or any other disease or disorder of the heart or arteries?	❑ Yes	❑ No
b)	Jaundice, anaemia, piles, ulcers, dysentery, diabetes mellitus or any other disease of the stomach, liver, spleen, gall bladder or pancreas?	❑ Yes	❑ No
c)	Asthma, bronchitis, pleurisy, tuberculosis or any other disease or disorder of lungs?	❑ Yes	❑ No
d)	Paralysis, epilepsy, fits or any kind of nervous breakdown or any other disease related to the brain or the nervous system or arthritic, skeletal or joint disorders?	❑ Yes	❑ No
e)	Any disease or disorder of ear, nose, eyes or throat, including defective sight or hearing and discharge from ears?	❑ Yes	❑ No
f)	Cancer, leprosy, rheumatism, gout, enlarged glands or tumors?	❑ Yes	❑ No
g)	Any disease or disorder of kidney, prostate, urinary system or reproductive system?	❑ Yes	❑ No
h)	Hernia, hydrocele, goitre, gonorrhea, syphilis or any other venereal disease?	❑ Yes	❑ No
i)	Any other illness/impairment/disability not mentioned above?	❑ Yes	❑ No
j)	Is the life to be insured or partner HIV positive or suffering from AIDS, hepatitis?	❑ Yes	❑ No
k)	Has the life to be insured or partner ever been tested for HIV/hepatitis, other than routine testing for insurance or employment?	❑ Yes	❑ No
l)	Does the life to be insured have any physical defect/ deformity?	❑ Yes	❑ No
m)	Has the life to be insured ever had any accident requiring hospitalization or undergone any treatment or operation for any ailment not mentioned above?	❑ Yes	❑ No

If the answer to any of the above questions 4 and 5 is YES, kindly furnish details below				
Sr.No.	Nature of ailment /disease etc.	Date of Diagnosis	Fully recovered / still under treatment	Name, Address and Telephone Number of the attending physician

6.	FOR FEMALE LIVES TO BE INSURED ONLY		
a)	Is the life to be insured pregnant now?	❑ Yes	❑ No
b)	Has the life to be insured had any abortion or miscarriage or caesarian section	❑ Yes	❑ No
	If the answer to a) or b) above is "**YES"** then please give details		

7. PARTICULARS OF DOCTOR OF LIFE TO BE INSURED

(State the name and address of your usual doctor who attends in the event of illness or if you have been consulting with the doctor for less than three months the name and address of your previous doctor)

Title	Surname	First Name	Middle Name
D R .			

Address of the Doctor:

											City/Village																			
State:																					Pin:							

Telephone Numbers (With STD Codes)

Residence:												Office:											
Mobile:												E-mail:											

8. DECLARATION BY THE LIFE TO BE INSURED

I declare that I have answered the questions in this form after fully understanding the nature of the questions and the importance of disclosing all information while answering such questions. I further declare that the answers given by me are complete in every respect and that I have not withheld any material information or suppressed any fact.

I further declare that this form will be the basis for granting me insurance cover and if any untrue statement is contained in this form, Kotak Mahindra Life Insurance Company Ltd, shall have the right to vary the benefits which may be payable and further if there has been a non-disclosure of a material fact the insurance to which this form relates may be treated as void and all premiums paid to procure and keep in force insurance for the life to be insured under this policy may be forfeited to the Company.

I hereby authorise my employer / the policyholder, doctor or hospital to divulge to the Company any information required by them in connection with this form.

I understand that the insurance cover provided will be governed by the provisions of the Insurance Act, 1938 and the Policy Contract under which this cover is being offered by the Company and that cover will not commence until the Company's written acceptance of this application is received.

Place :	Date :
Signature/ thumb impression * of the life to be insured	**Signature of the authorised signatory of the Policyholder with rubber stamp**

* If a person other than the life to be insured fills the form then the person filling in this form on his/her behalf must sign the following declaration.

9.	DECLARATION BY THE SCRIBE (if different to the Life to be Insured)		
I _____, having known the life to be insured for a period of _____ do declare that I have explained the nature of the questions contained on this application to the life to be insured. I have also explained that the answers to the questions form the basis of the contract of insurance between the Company and the Policyholder and that if any untrue statement is contained therein the Company shall have the right to vary the benefits which may be payable and further if there has been a non-disclosure of a material fact the insurance to which this form relates may be treated as void and all premiums paid to procure and keep in force insurance for the life to be insured under this form may be forfeited to the Company.			
Place :		Date :	
Signature of the Scribe		**Address of Scribe**	

Name of Checker:		**Form Complete**	❑ **Yes**	❑ **No**
Follow up Action and Comments				
Date :		**Signature & Stamp of Policyholder:**		