PICIC INSURANCE

Health Declaration Form

IMPORTANT NOTE: Kindly disclose complete medical history in this form. Please note that if a pre-existing condition is NOT DISCLOSED, we can decline the claim relating to it. If the medical condition is disclosed, we may cover that medical condition, subject to the terms and condition of the policy.

Pre-existing Conditions are diseases, illnesses or injuries for which a person receives treatment, incurs expense, receives diagnosis from a doctor (even if no treatment is provided) or was aware of at anytime prior to applying for insurance.

Policy Holder:	
Employee Name:	
Designation : Joining Date	
Marital Status :	
N.I.C. # / Contact #	
Emp Code : Blood Group	

Family details:

Please write Family members (spouse, son, daughter) to be covered. Attach additional form, if necessary.

S. No.	Name in CAPITAL letters	Relationship	Gender (M/F)	Date of Birth	Marital Status / Occupation
1)		SELF			
2)					
3)					
4)					
5)					
6)					

COMPULSORY INFORMATION TO BE PROVIDED:

Are / have you or any member of your family listed above (spouse / children) currently or at any time prior to applying for insurance:	Yes	No
1) Consulted a medical practitioner or specialist within the last 12 months?	☐	☐
2) Suffered from or aware of any medical condition / disease / illness or injury (even if no doctor was consulted)?	☐	☐
3) Told by a doctor that surgery or special medical tests or treatment might be required or necessary at some future date?	☐	☐
4) Suffered from High Blood Pressure, Heart Disease, Diabetes, Paralysis, any disease of Brain or Nervous System, Renal Disease, Cancer or Tumor, Arthritis, Rheumatism, Disease / Disorder of the Liver, AIDS or any other disease or illness not mentioned above?	☐	☐
5) Regularly took medication for more than a week time (prescription or other)?	☐	☐
6) Suffered from any mental disability or physical disabilities or defects?	☐	☐
7) Is your spouse (or yourself, if you are a female? Pregnant? If yes, please state duration.....		

If you have answered 'YES' to any of the questions 1 - 7 above, please provide details i.e. name of a person, nature / duration of illness, name of attending physician / hospital, type of treatment and whether any further tests / treatment suggested / required. Attach additional sheets if necessary and also attach photocopies of the relevant medical reports / prescription of medicines.

DECLARATION: I hereby certify that I have filled the above information to the best of my knowledge and belief. I am also aware that subject to the terms of acceptance of my coverage, this declaration together with the letter of Policy Holder to the PICIC Insurance is the basis for the Group Health Insurance applied for. I authorize any hospital, physician or surgeon who has attended to me or my family members to furnish to PICIC Insurance with any and all information that they may require concerning our medical history and / or examination

Plan ☐ A ☐ B ☐ C ☐ D
☐ E ☐ F ☐ G ☐ H

_____ _____ _____ Date Of Coverage _____