

**Policy Revival/ Increase
In Sum Assured Form**



PSA000101

7. Have you ever been investigated/treated or diagnosed with any of the following conditions?

Hypertension/High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest Pain/Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other heart disease/problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV infection/AIDS or positive test to HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes/High blood sugar/sugar in urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous, Psychiatric or mental disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizure, Stroke/Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis, or any other Lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver problems/Jaundice/Hepatitis B or C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney problems or disease of reproductive organs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer/Tumor or growth, Cyst of any kind	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood disorder (Such as Haemophilia, Thalassemia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Thyroid Disorder or any other hormonal disorder, any stomach disorder, Urinary disorder, reproductive disorder, any congenital disorder, Anemia or any other blood disorder, Depression Any other condition, symptom, disease not stated above

8. Have you suffered from any accident or injury from the date of lapse till the date of this application for Revival? Yes No

9. Is your occupation associated with any specific hazard or do you take part in activities or have hobbies that could be dangerous in any way for example paragliding, bungee jumping, etc.? Yes No

10. Do you have two or more members of your family who have (father,mother,brother(s) or sisters(s)) suffered from or are suffering from cancer, heart disease, kidney failure, stroke, diabetes, or any hereditary disease? Yes No

11. Have ever been convicted or are you under investigation for an criminal charges? Yes No

12. Have you ever tested positive for the novel corona virus (SARS-CoV-2/COVID-19) which required hospitalization/ ICU admission/put on ventilator ?
(If Yes, please submit Covid Questionnaire) Yes No

If responses to any of the questions for 1 to 12 above are yes, please provide details below or attach a separate sheet (if necessary) in the same format which should be duly signed

Date of event/ diagnosis	Diagnosis	Investigations Done	Treatment Details	Name, address & contact number of the doctor/ hospital	Current status (including current medication)

13. Please attach copies of reports/dischARGE summary as mentioned in 5.

14. Have you been away from work for a continuous period of more than 7 days due to health reasons ? Yes No
If yes, please provide details

15. Are you pregnant now? (Applicable for females only) Yes No

If yes duration in weeks _____

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I/We declare that I/We 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/We further declare that the answers given by me /us to all the questions in this form are true and complete in every respect and that I/ We have not withheld any material information or suppressed any fact.

I/We further declare that this Policy Revival/Increase in Sum Assured form will also be the basis of the contract of insurance and if any untrue statement is contained in this form, 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 Policy may be treated as void and all premiums paid under the Policy may be forfeited to the Company.

If the Life Assured commits suicide for any reason, within one year from Revival of the Policy, no Benefits shall be payable under this Policy, other than the Fund Value as at the date of notification of death.

In order to enable the Company to assess the risk under my policy and any time thereafter, I hereby authorize my past and present employer(s) doctor/hospital/any Life and Non Life Insurance Company/or organization or Life Insurance Associations medical register to release to the Company and the Company to release to any medical source/any life and non life insurance company/or Life Insurance Association's medical register or Government authorities, such details and provide such records of my employment/business or other details as may be required/considered relevant. I give my consent to the Company or its agents to undertake the medical tests necessary for assessing my Policy for Revival/Increase in Sum Assured. I understand this may involve blood tests including HIV antibodies. I declare that in the event of being medically examined by the Company the answers given to the medical examiner authorized by the Company and in the questionnaires provided by the Company will be deemed to be part of the statements and answers given in this application. I/We understand that my/our policy will not be considered for revival/increase in sum assured until the company's written acceptance of this application is received. Please note that policy revival/increase in sum assured form should be signed by both life assured and policy holder.

I/ We authorize the Company to seek/ store or/ and to share my KYC details from/ with (i) Governmental and/ or Regulatory Authority, (ii) Insurance Repositories (iii) CERSAI/ UIDAI (iv) reinsurers/ group companies/ hospital or diagnostic centers/ other insurance companies or third parties for underwriting assessment, claim investigation/ settlement, KYC authentication, policy servicing purpose and such like purposes.

Name of Life Assured

Signature/Thumb Impression of Life Assured
(Incase of change in signature from Original, refer to
Point no. 7 under Instructions section)

Name of Policy Holder/Assignee

(Assignee details required in case of Absolute Assignment of Policy)

Signature/Thumb Impression of
Policy Holder/ Assignee

Date

D D / M M / Y Y Y Y

(Mandatory)

Place

(Mandatory)

Vernacular Declaration (to be filled if this form is signed in Vernacular/affixed thumb impression)

I hereby declare that I have explained the contents of this form to the Policyholder Mr/Mrs/Ms _____ in _____ language and that the Policyholder has affixed the thumb impression(s)/signed in language other than English in my presence after fully understanding the contents thereof.

Name of the Declarant _____ Place _____ Date _____ Signature of the Declarant _____

Canara HSBC Life Insurance Company Limited
IRDAI Regn. No. 136

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