

Brother		<input type="text"/> <input type="text"/> <input type="text"/> yrs	<input type="text"/> <input type="text"/> <input type="text"/> yrs
Sister		<input type="text"/> <input type="text"/> <input type="text"/> yrs	<input type="text"/> <input type="text"/> <input type="text"/> yrs
Sister		<input type="text"/> <input type="text"/> <input type="text"/> yrs	<input type="text"/> <input type="text"/> <input type="text"/> yrs

8.	For Female lives only:	
	i. Have you ever suffered/are you suffering from any gynaecological problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	ii. Are you pregnant at present? If "Yes" what is the expected date of delivery? <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	iii. Have you had any complications, miscarriage, medical termination of pregnancy or Caesarian Section?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details of questions ticked as "Yes" _____		

9.	Habits		
Substance Consumed	(If "Yes", Please tick the substance and quantity consumed)	Quantity/day	Consuming Since
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cigarette <input type="checkbox"/> Bidi <input type="checkbox"/> Cigar <input type="checkbox"/> Pan Masala	<input type="text"/> <input type="text"/> Pouches/day <input type="text"/> <input type="text"/> Sticks/day	<input type="text"/> <input type="text"/> <input type="text"/> Years
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Hard Liquor	<input type="text"/> <input type="text"/> ml/day	<input type="text"/> <input type="text"/> <input type="text"/> Years
Drugs not prescribed by doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Stimulants <input type="checkbox"/> Sedatives <input type="checkbox"/> Narcotics <input type="checkbox"/> Others If others, specify <input type="text"/>	<input type="text"/> <input type="text"/> ____/day	<input type="text"/> <input type="text"/> <input type="text"/> Years

10.	Do you take part or intend to take part in parachuting/hand gliding/scuba diving/mountaineering/ car racing/flying other than as a bonafide passenger/any other hazardous pastimes. Please specify _____ (If "Yes", please complete respective questionnaire)	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Are you planning to travel in the next one year or reside abroad other than on holiday? If "Yes", please provide details along with duration of stay _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Declaration by the Life Assured/Applicant

I hereby declare and agree that the above mentioned particulars/answers are complete and true to the best of my knowledge. I also authorize the company to obtain, if necessary, confidential reports from the doctor /clinics / hospital that I have referred above or on my any medical reports done by IDBI Federal Life Insurance or any other relevant medical reports submitted by me.

I agree that this form will constitute part of my application for life assurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of Life Assured/Applicant: _____

Date: _____

Place: _____

Vernacular Declaration

I have explained the contents of this proposal to the Proposer Mr. /Ms _____ having applied with proposal no. _____ in (Language) and ensured that the contents have been fully understood by him /her. I have accurately recorded the Proposer's responses to the information sought in the proposal form and I have read out the responses to the Proposer and he/she has confirmed that they are correct.

Signature of the person making the declaration: _____

Name of Declarant: _____

Address: _____

Date: _____

Place: _____