DECLARATION

I, hereby authorize Dr.______________________________ to intimate LIC of India all necessary information about my health obtained on history, examination including diagnosis and treatment.

I hereby declare that the statements and Answers to Questions in Part One and Part Two of this report are true and complete and do hereby declare that these will form part of the proposal dated ____________ given by me to LIC of India.

________________________________
Signature of the L.A.

PART-I

1. Full Name of Life to be assured (L.A.) ______________________________________________

2. Has the L.A. suffered from ______________________________________________________
   Heart Disease (Y/N)  Hypertension (Y/N)  Diabetes (Y/N)
   (If yes, state name, address of the Consultant and submit all relevant papers with this form)

3. Does L.A. consume tobacco, snuff, other narcotic substances in any form?
   No of Years  Quantity used  Date of cessation, if any

4. Does L.A. consume alcoholic drinks?
   No of Years  Quantity used  Date of cessation, if any

Dated: ________________

Signature of Physician
Name: __________________________
Address: ________________________
Qualification: ____________________
Reg.No. _________________________

Note: if Q.2 of Part-I is negative, no need of filling up Part-II
**Part II**

1. If L.A. ever treated/hospitalized for any heart disease, hypertension, and diabetes  Y / N *
   (If ‘Yes’, then details of—

<table>
<thead>
<tr>
<th>Investigations</th>
<th>Treatment</th>
<th>Hospitalisation</th>
<th>Present Status</th>
<th>Prognosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Blood Pressure Reading:-

<table>
<thead>
<tr>
<th>Current</th>
<th>At the time of detection of HT</th>
<th>Duration of HT, if taking regular treatment</th>
<th>Prognosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Diabetes:

<table>
<thead>
<tr>
<th>Date of Diagnosis</th>
<th>Type</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Are there any symptoms / signs of

   (a) Renal Disease
   (b) Neurological involvement
   (c) Eye Involvement
   (d) Peripheral Vascular Disease
   (e) Any other infectious disease (esp: TB)

5. Is L.A. taking regular treatment for above disease / s?

   *(Enclose all relevant papers with this form)*

---

Signature of the L.A. ___________________________  Signature of Physician _________________________
Name: ___________________________  Address: ___________________________
Qualification: ________________________  Reg.No. ___________________________