

REQUEST FOR MAJOR REVIVAL OF POLICY

Note : On review of the Major revival form, you may have to undergo medical tests / physical examination

I POLICY DETAILS

Policy Number																			
Client ID																			
NAME OF THE LIFE INSURED																			
Mr/Ms/Title					Surname					First name					Middle name				
NAME OF THE POLICY HOLDER (IF DIFFERENT FROM LIFE INSURED)																			
Mr/Ms/Title					Surname					First name					Middle name				
II) Occupation Details of life to be insured (if life insured is minor / housewife – then of Proposer)																			
i) Please select one or more categories as applicable :																			
<input type="checkbox"/> Employed <input type="checkbox"/> Self – Employed <input type="checkbox"/> Professional <input type="checkbox"/> Student <input type="checkbox"/> Housewife <input type="checkbox"/> Others																			
ii) Name & Address of the Present Employer										iii) Designation :									
										iv) Annual Income :									
										v) Years of service :									
vi) Is the occupation of the Life Insured associated with any specific hazards (which would render the Life Insured susceptible to any injury or illness)?										<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, kindly provide details :									
vii) Is the Life Insured engaged in or does he / she have any intention to take part in any hazardous hobbies / activities (which would increase the risk of any injury or illness to the Life Assured)?										<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, kindly provide details :									

PERSONAL STATEMENT REGARDING HEALTH OF LIFE INSURED / POLICY HOLDER (if different then life insured)

		Life Insured	Policy Holder (if diff from life insured)
1	Height (cms)		
2	Weight (kgs)		

3. Since the Date of your Proposal, has the Life Insured :

		Life Insured	Policy Holder (if diff from life insured)
a)	Consulted a Medical Practitioner for any ailment /injury requiring treatment for more than 7 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b)	Remained absent from his/her place of work for more than 7 days, on health grounds or claimed against his/her health insurance policies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c)	Undergone any cardiological / pathological or radiological tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Since the Date of your Proposal, has the Life Insured suffered from / is suffering from :

		Life Insured	Policy Holder (if diff from life insured)
a)	High or low blood pressure, rheumatic fever, chest pain, myocardial infarction or any other disease or disorder of the heart or arteries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b)	Jaundice, anaemia, piles, ulcers, dysentery, diabetes mellitus or any other disease of the stomach, liver, spleen, gall bladder or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c)	Asthma, bronchitis, pleurisy, tuberculosis or any other disease or disorder of lungs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e)	Any disease or disorder of ear, nose, eyes or throat, including defective sight or hearing and discharge from ears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f)	Cancer, leprosy, rheumatism, gout, enlarged glands or tumors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g)	Any disease or disorder of kidney, prostate, urinary system or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h)	Hernia, hydrocele, goitre, gonorrhoea, syphilis or any other venereal disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i)	Any other illness/impairment/disability not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j)	Is the life to be insured or partner HIV positive or suffering from AIDS, hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k)	Has the life to be insured or partner ever been tested for HIV/hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l)	Does the life to be insured have any physical defect/ deformity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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5. If the answer to any of the above questions contained in 3 or 4 above 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 treating doctor

6. For female lives only				
		Life Insured		Policy Holder (if diff from life insured)
a)	Is the Life Insured pregnant now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b)	Has the Life Insured had any abortion or miscarriage or caesarian section after the date of the proposal.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7	Is any proposal or an application for revival of a lapsed Policy on your life / the life insured under consideration of this Company or any other Insurer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	If yes, please give details -				
	Company name	Sum assured			Plan name
		On death	On accidental death	On disability	On Critical illness

8	Additional details - Please give usage of the following - LI = Life Assured PR = Proposer (if different from LI)														
	Usage of the following	Yes / No		Form of consumption		Average usage *per day		Usage in past Yes / no		If yes, form of consumption		Past average usage * per day		Reasons for giving up	
		LI	PR	LI	PR	LI	PR	LI	PR	LI	PR	LI	PR	LI	PR
	Alcohol														
	Tabacco														
	Any Narcotics														

DECLARATION BY THE LIFE INSURED AND POLICYHOLDER
(if different from the Life Insured)

I/We declare that I/We have answered the questions in this Policy Revival 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 undertake to notify KOTAK MAHINDRA OLD MUTUAL LIFE INSURANCE LTD. of any change in the state of health of the life to be insured or as to his/her occupation or any decisions about his/her existing policies or proposals subsequent to the signing of this form and before the acceptance of the risk by KOTAK MAHINDRA OLD MUTUAL LIFE INSURANCE LTD.

I/We further declare that this policy revival 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.

I/We hereby authorise the employer, doctor or hospital of the life to be insured to divulge to the Company any information required by them in connection with the policy contract.

I/We understand that the contract will be governed by the provisions of the Insurance Act, 1938 and that the contract will not commence until the Company's written acceptance of this application is received.

Date :	Place :
Signature/ thumb impression * of the Life Insured	Signature/ thumb impression* of the Policy Holder (if different from the life to be insured)

* If a person other than the Policy Holder fills the form, then the person filling this policy revival form on his / her behalf must sign the following declaration :

DECLARATION BY THE PERSON FILLING IN THE FORM
(For forms filled in by a scribe or for forms signed in vernacular languages)

I _____, having known the Policy Holder for a period of _____ do declare that I have explained the nature of the questions contained on this application to the Policy Holder. I have also explained that the answers to the questions form the basis of the contract of insurance between the Company and the Policy Holder 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 policy may be treated as void and all premiums paid under the policy may be forfeited to the Company.

Date :	Place :
Signature of the Scribe	Address of Scribe: Signature of the Scribe