Group Pre-existing and Critical Illness Declaration Form

To: Insurance Company

We (Name of Insured/Policyholder) hereby confirm that the below information is correct and has been provided after verifying the same with all members to be insured with Insurance Co. as of (date)

Any member(s) suffered in past, diagnosed, or received any treatment in relation to or continuing treatment for:

1.	Any Critical Illness including Cancer, Leukaemia, Tumour, Hepatitis, HIV/AIDS etc.	Yes ☐	No ☐
2.	Heart Disease, Neurological Disorder (Epilepsy etc).	Yes ☐	No ☐
3.	Spinal Disorders including Lumbo-sacral Disc Disorders, Accidental Injuries.	Yes ☐	No ☐
4.	Covid-19.	Yes ☐	No ☐
5.	Auto Immune Disorders like, Psoriasis, Rheumatoid Arthritis etc.	Yes ☐	No ☐
6.	Major Surgical Procedures due or performed in the last 1 year.	Yes ☐	No ☐

In addition to the above, we hereby understand and agree that:

1. Insurance Co. has the right to re-underwrite and propose new premiums based on above information.
2. **Individually Completed Health Declaration From shall be provided for members above age 65 and/or with any of the above conditions and/or currently Pregnant.**
3. If we failed to disclose any of the above conditions for any reason, we understand that Insurance Co. has the right to decline any claim related to these conditions for non- disclosure of material fact and accordingly we shall be liable to settle and reimburse any paid amounts back to Insurance Co.
4. After inception of the policy if we come to know of any of the above conditions previously unreported, we undertake to inform Insurance Co. promptly thereafter for their appropriate action.

For and on behalf of

(Policyholder) Date

Authorized name and

signature Stamp