Group Pre-existing Conditions
Declaration

To:

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 as of (date)

Has any member ever suffered, diagnosed or received any treatment in relation to:

1. Liver Problems	No	☐	Yes	☐
2. Renal Problems	No	☐	Yes	☐
3. Stroke, bypass or heart surgeries	No	☐	Yes	☐
4. Cancer/Tumor	No	☐	Yes	☐
5. Person in COMA	No	☐	Yes	☐
6. COPD (Chronic Obstructive Pulmonary Disease)	No	☐	Yes	☐
7. Ongoing Pregnancy /Maternity	No	☐	Yes	☐

(If Yes, fill the below table)

Name	Age	Last Menstrual Period (LMP)	Expected Date of Delivery (EDD)	Number of Live Births (Gravida Status)

I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of the insurer. The insurer has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of the insurer.

9. If any other ailment, kindly specify.

10. If any member is above age 65 and above	No	☐	Yes	☐
11. Auto Immune Diseases such as AIDS, systemic scleroderma, Etc.	No	☐	Yes	

If any of above are answered “YES” please provide details below

Member Name	Pre-existing Condition/ailments	Reports attached

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

1. Insurer has the right to re-underwrite and propose new premium based on above information
2. Members aged 65 years and above or with pre-existing/chronic conditions will have to submit Individual health declaration forms.
3. All additional members to the policy will have to declare all pre-existing conditions in relation to above listed conditions.
4. If we failed to disclose any of the above conditions for any reason, we understand that insurer has the right to decline any claim related to these conditions for non- disclosure of material fact and we shall also be liable to settle and reimburse any paid amount back to insurer.
5. After inception of the policy if we come aware of any of the above conditions previously not reported, we undertake to inform insurer promptly thereafter for their appropriate action.

For and on behalf of

(Policyholder)

Date

Authorized Signatory

(Name, Signature & Stamp)