Chartered Life

Secured Life

(CS Form-13)

PART - 1

DECLARATION OF GOOD HEALTH (DGH)

Policy No :		
Premium Due Date:	Plan & Term:	Agency :

QUESTION TO BE ANSWERED BY POLICY OWNER

	NAME	DATE OF BIRTH	PRESENT AGE	HEIGHT	WEIGHT
INSURED					
OWNER					
SPOUSE					
DEPENDENT(S)					

1. Present Occupation of Owner : _____

2. Have you ever been affected any disease or injury after first declaration of your health condition? ☐ Yes ☐ No

   If yes, please give in details : _____

3. If any member of your family died after declaration of first physical healthiness (Father, Mother, Sister, Brother)? ☐ Yes ☐ No

   If yes, write Date of Death, Cause of Death, Age & Duration of illness : _____

4. Have you ever been presented an application for new insurance which was declined? ☐ Yes ☐ No

5. Does any of the insured's intend to seek medical advice, treatment or have any medical treatment tests performed? ☐ Yes ☐ No

6. Are you & all other insured's now in good health? (If no, explain in details) ☐ Yes ☐ No

FOR FEMALE

7. Are you pregnant now? (If yes, how many months) : ☐ Yes ☐ No

Other Insurance Policies including Policy with Chartered Life:

POLICY NO	COMPANY NAME	FACE AMOUNT	SUPPLIMENTARY CONTRACTS

I UNDERSIGNED APPLICATION OF LIFE INSURANCE/POLICY OWNER DECLARED THAT:

1. I declare that the statements given above are true and complete to my knowledge & I didn't conceal or deviate any information which can be difference in risk of the policy.

2. Till now after my first declaration I am not affected any disease or injury and not any changed in y family.

3. I agreed that if any information is proved untrue, the company shall have the right to take any legal action.

4. For this life insurance my present, previous and future declaration will be treat as insurance agreement between Chartered Life Insurance Company Limited and me.

CODE TRANSFER (if 180 days expired from next due date of premium)

1. Would you like to change your organizer code? ☐ Yes ☐ No (If Yes) Please Write **New Code** _____

Name & Signature of FA with code no/Medical examiner with seal & ID no

Place of signing	:
Date	:
Cell No	:

Name & Signature of the applicant

Place of signing	:
Date	:
Cell No	:

Witnessed By:

BM/Marketing Executives

Name _____ Signature _____ Code No _____

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PART II : MEDICAL EXAMINATION
IMPORTANT : PLEASE CHECK IDENTITY OF INSURED

Type of identification: ..... Number ..... Signature of insured .....

1. A. How long have you known the Insured? ..... B, Are your related? ..... C. Race .....

A. Height.....Ft.....Ins C. Did you { *Weigh,him / her ?* / *Measure, him / her ?* } ❐ Yes ❐ No ❐ Yes ❐ No D. Girth (males only) { Chest Forced Expiration ..... Ins / Chest Full Inspiration n ..... Ins / Abdomen at Umbilic us ..... Ins }

b. Weight ..... Lbs

	Yes	No
3. Does inquiry or examination reveal any past or present disease of brain, chest, digestive, genitor-urinary, cardio-vascular, renal Glandular or nervous system? (Give Details)		
4. A. Is his appearance unhealthy?		
B. Does he appear older than age given? (Why)		
C. Is there any impairment of sight or hearing?		
D. Are pupillary and patellar reflexes abnormal?		
E. Is there any deformity or other physical defect?		
f. Has serological test for syphilis ever been made?		
G. Are there any abdominal varicosies or hernias? (Locate, describe in details)		
H. How, Do you know anything about his characters morals which would affect the risk adversely?		

10. Name and address of this medical examiner

.....

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DETAILS (Mention Ref. Question Number)

5. Pulse per-minute	Rate at rest	* After exercise	5 minutes later

Irregularities per-minute *25 beats above resting)

6. Blood pressure	Systolic	Diastolic (5th phase)

7. Is there any evidence of arteriosclerosis or aneurysm? Yes ❐ No

8. Is there {a heart murmur?.....} any hypertrophy?.....} Describe in details

9. A. Urinalysis	Specific Gravity	Sugar	Albumin

B. Are you satisfied that the specimen is authentic?.....

Dated at .....

(city)

this..... day of ..... 201.....

.....

Signature of Medical Examiner with SEAL and ID No.

FOR HEAD OFFICE USE ONLY

❐ Referred to Underwriting Dept.

UNDERWRITING COMMENTS:

❐ Signature Differs ❐ Approved ❐ Postponed ❐ Declined

❐ Medical& Urinalysis of Policy Owner/insured required {due to NMP-0/Coverage/Age/Claim) ❐ Additional Comments :

❐ Reinstate policy of Husband/Father/Mother first

❐ Fresh CS-Form required

❐ Others ;

UNDERWRITER

UNDERWRITER