



Sri Lanka Insurance  
Corporation Ltd

**Short Form Health Declaration – Sri Lanka Telecom PLC**

**A. Details of the Life to be Insured**

(1) Full Name :		Effective Date (DD/MM/YYYY):	
Permanent Address :		N.I.C No. : Contact No. :	
(2) Sex: Male ___ Female ___ Marital Status : Single ___ Married ___ Smoker: Yes ___ No ___		Date of Birth (DD/MM/YYYY): Age (nearest birthday): _____	
If you are a Smoker Pls. state how many cigarettes per day do you smoke : .....			
(3) Occupation (*):		Nature of Duties:	
(4) Annual Income :		(5) Height : _____ Cms. Weight: _____ Kgs.	
(6) Employer's Name and Address:			
(7) Previous Insurance Details:			
Insurance Company Name	Amount Insured	Policy No.	Month and Year of Policy taken
<b>(8) B. Health Declaration for Proposed Life Insured</b>			
1. Are you suffering or have you ever suffered from any illness / disease/ ailment up to the date of making this health declaration or suffer from any physical or mental condition?	Yes	No	
2. Have you ever suffered in the past for: symptoms of high blood pressure, diabetes, heart attack or disease, stroke, chest pain, kidney disease, AIDS or positive HIV test, cancer or tumour, asthma or respiratory disease, mental or nervous disease, liver disease (including hepatitis B carrier), blood disease, digestive and bowel disorder, arthritis or deformities or any other not stated above?	Yes	No	
3. Have you ever been hospitalized up to the date of making this health declaration?	Yes	No	
4. Within the past three years, has any of your application for Life or health insurance declined or accepted at modified terms?	Yes	No	
5. Do you participate or do you intend to participate in any hazardous sports or activities?	Yes	No	
6. Have you ever received or do you now receive any disability benefits?	Yes	No	
7. Are you pregnant ( for females only) ? If yes, please state how many months ?	Yes	No	
8. Has anyone in your family (father, mother, brother(s) or sister(s)) died before age 50 or have suffered from cancer, heart disease, kidney failure, stroke –	Yes ___	No ___	

**(If you answered “YES” to any of the above questions numbered 1 to 8 (in Health Declaration section), please give complete details (including dates, duration and treatment, names and addresses of physicians) on the back of this form and include your signature and the date)**

**C. Declaration by the life to be insured**

I understand and agree that the answers and statements made on this Health Declaration are full, complete and true in every particular and will form the basis of the contract, which may arise. All material facts, being facts, which may influence the assessment of this risk, have been disclosed in this Health Declaration, it being understood by me that failure to make such disclosure renders the contract voidable. I consent to Sri Lanka Insurance Corporation Ltd. seeking medical information from any doctor in respect of any matter relating to my physical or mental health and I authorise and consent to him/any hospital giving such information to Sri Lanka Insurance Corporation Ltd. and/or to the claims administrator or medical advisors.

\_\_\_\_\_  
Signature of the life to be insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Place

\_\_\_\_\_  
Signature & rubber Stamp of the proposer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Place