ANNEXURE 1

Life Insurance Corporation of India

(Established by the Life Insurance Corporation Act 1956)

…….. Branch Office …… Divisional Office

Name of the Proponent / Life Assured:_____

QUESTIONNAIRE TO BE COMPLETED BY THE PROPONENTS / POLICYHOLDERS / PERSONAL MEDICAL ATTTENDANT/ MEDICAL EXAMINER REGARDING DEFORMITY (IES) AND / OR IMPAIRMENT(S)

1.(a) What is the cause of deformity ? :
Whether it is :
(i) Congenital :
(ii) Due to an accident or injury :
(iii) Due to any underlying disease :
(b) Since when the deformity is present :

2. If the deformity is due to any underlying disease, please state the following :
(i) What was the disease leading to deformity :
(ii) When did it occur :
(iii) Whether the disease is stationary or progressive :
(iv) If stationary, since when :

3. Does he/she have control on bowel movements and bladder? :

4. Exact parts of the body affected and extent :

5. Are there any restrictions in movements and function of the limb(s) or affected parts
Please give degree of disability :

6. Has he/she a limp? :

7. Whether the proposer / policyholder can walk and run fast without any aid (in case of deformity in the leg) :

8. Can he/she sqat, sit and get up properly? :

9. Whether the affected limb is shorter than the other, and if so to what extent (in cms) :

10. If the deformity is due to Poliomyelitis, please state :

whether the wasting or muscles is mild, moderate or severe. (Degree of wasting to be specified)

11. How many limbs are affected :

12. Any restriction in movement of any of the fingers or if any of the fingers are removed, if so, upto which phalanx. Whether thumb and forefingers have been affected/ removed :

13.(a) Whether the proposer/ policyholder can lift the articles without any difficulty and hold the articles without losing the grip (in case of deformity in the hands) :

(b) Is the grip firm and strong

14. My diagnosis as to the cause of the disability is _____
_____
_____

I do for the reasons explained below / do not have a reason, to suspect on clinical grounds a recent deterioration causing more pronounced disability

He/she is not able to perform routine self care activities.

He/she is not required to use wheel chair / crutches.

Any other factors which are likely to add to the risk on account of the deformity/ies.

15. Please submit details of previous treatment, previous special reports X-Ray etc. for perusal and return.

Dated at _____ on the _____ day of _____ 200 _____

_____
Signature of the proposer/
Policyholder

_____
Signature of the Medical
Examiner/Medical Attendant

Code No. :
Qualification :
Reg. No. :
Address :