FORM NO.:NB/59
Annexure 1445/4 dt.28.8.89
ANNEXURE – I

LIFE INSURANCE CORPORATION OF INDIA

_____ DIVISION

----------**Branch Office**

DEFORMITY QUESTIONNAIRE

Name of the proponent/Life Assured :----------

QUESTIONNAIRE TO BE COMPLETED BY THE PROPONENTS/POLICY HOLDERS/PERSONAL MEDICAL/ ATTENDANT/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,
OR
(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 stationery or progressive.
(iv) If stationery, since when

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

4. Exact parts of the body affected and extent

4. Are there any restrictions in movements and function of the limbs or affected parts. Please give degree of disability

6. Has he/she a limp ?

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

8. Can he/she squat, 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 of 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 forefinger 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 ?

13. My diagnosis as to the cause of the disability is……

…….

……

I do for the reasons explained below / do not Have any reason to suspect on clinical grounds A recent deterioration causing more pronounced Disability.

He/She is not able to perform routine self-care Acticities.

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.

14. Please submit details of previous treatment, Previous special reports, x-rays etc. for Perusal and return.

Dated at_____on the _____day of_____20___

Signature of the proposer/
Policyholder

Signature of the Medical Examinder/
Medical Attendant.

Code no:

Qualification:

Registration no:

Address: