ANNEXURE - A

LIFE INSURANCE CORPORATION OF INDIA

Divisional Office . Branch Office .

Claim for Disability/Sickness Benefit under Nav Prabhat Plan
(Questionnaire to be completed by the Doctor/Hospital who/which treated the life assured for his ailments/injuries/disability)

Policy No.: _____ Claim No.: _____

Name of the Patient: _____ Age: _____

Address: _____

Identification mark : _____

I. (i) Details of first Consultation/Admission : (a) Date:
(b) Time:
(c) Place:

(ii) Exact history reported at the time of consultation/admission :

(iii) Name of the person who reported the history and his relationship with the LA :

II. Examination and Diagnosis:

(i) Describe in brief the symptoms of illness :

(ii) Nature of injuries :

(iii) Cause of injuries

(a) Accident :

(b) Self infliction:

(c) Riots/Civil commotion/
War/Breach of Law:

(iv) Cause of sickness :

(v) If under influence of alcohol/
intoxicating drugs:

(vi) If suffering from HIV infection/AIDS:

(vii) Did you find the symptoms/nature of injuries noticed on examination consistent with the history reported on consultation/admission and if not, please state what in your opinion could have caused the symptoms/injuries

(viii)What is your final diagnosis? :

III. Treatment details:
(i) During hospitalization :
(ii) During follow up:
(iii) Current Treatment:

IV. (i) State present health status :
(ii) If disabled, Nature of disability (Permanent/Temporary) :
(iii) The nature of deformity/ injury/disease/ illness in brief, which contributed to the causes leading to the disability :
(iv) Extent of disability :
(v) Percentage of disability :
(vi) Do you consider that the patient is unable to attend to his occupation permanently :
(vii) If temporary, approximate time required for full recovery :

V. Have you any additional information or comments concerning the ailments, habits or condition of the patient which may have a bearing on the disability ?

(N.B.- Please enclosed certified copies of the case papers maintained by the Doctor/Hospital on the basis of which the above information is given in the questionnaire.)

Certified that the above information is correct as per records maintained by me/the hospital.

Signature:
Name of the Doctor/ Hospital:
Registration number:
Address :
Telephone number:

Date:
Place:

_____
Signature or thumb impression of Life Assured
in presence of the Doctor