ANNEXURE - C

LIFE INSURANCE CORPORATION OF INDIA

Divisional Office _____ Branch Office _____

Claim for Disability/Sickness Benefit under Nav Prabhat Plan

Questionnaire on ACTIVITIES OF DAILY LIVING (ADL) TEST
(To be completed by Medical Examiner on LIC Panel after examining the Life Assured)

Policy No. : _____ Claim No. : _____

Name of Life Assured : _____ Age : _____

Address:_____

_____

_____

Details of Photo Identity of the person examined (Passport/Driving Licence/PAN card/Voter s Identity Card) :

Nature of Proof : _____ Serial Number of the document: _____

Date of birth on the document: _____

Introduced by : _____

_____

Date of Accident/Detection of Disease/Disorder : _____

Date of confirmation of disability :_____

1. What is the cause of Accident/Sickness ?

2. What is his/her present condition ? Please provide details of disability with organs affected and extent of disability.

3. Mention details of treatment taken so far, including surgery, physiotherapy, any other.

4. Is the person presently under any treatment ? If yes, please provide details.

5. Please confirm whether the life assured has the ability to do the following :

a) Dressing and Undressing : To dress and undress and to put on/take off any surgical appliances usually worn?
b) Washing and Bathing : To wash in the bath or shower or by other means to maintain personal cleanliness?
c) Using the Lavatory :To get to and from the lavatory, to get on and off the lavatory and to maintain an adequate level of hygiene?
d) Continence : To voluntarily control bowel and bladder functions or to otherwise maintain an adequate level of personal hygiene with or without the use of catheters, incontinence pads or other artificial aids?
e) Mobility : To walk 400 meters on the level without stopping and without severe discomfort?

6. In your professional opinion, do you consider the disability as permanent and irreversible/ irrecoverable. Please provide details

(Kindly enclose Xerox copies of proof of identity and particulars of all treatment taken, consultations, investigations and follow up reports as well as Hospital Discharge Summary.)

_____
_____
Signature or thumb impression of Signature of Medical Examiner
Life Assured before Medical Examiner Name :

Address and Registration No:

_____
Signature of witness

Date : _____ Place:_____