Form No.5280

LIFE INSURANCE CORPORATION OF INDIA

Divisional Office .....

Branch Office .....

Re: Claim for Disability Benefit under policy No.....on the life of.....

(Questionnaire to be completed by the Doctor/ Hospital who/which treated the life assured for his ailments/injuries/disability).

I. (i) Name of the Patient:

(ii) Apparent Age:

(iii) Occupation

(iv) Full Address:

(v) Marks or physical peculiarities for purposes of identification:

II. (i) Consultation / Admission:

(a) Date:

(b) Time:

(c) Place:

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

(iii) Who reported the history

III. Examination and Diagnosis:

(i) Kindly describe in brief the symptoms of the illness/the nature of injuries noticed on examination:

(ii) 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:

(iii) What was the final diagnosis?

IV. (i) Treatment:

(ii) Particulars of treatment given:

V. (i) What is the conditon of the patient at present:

(ii) D o you consider that the patient is now incapacitated and cannot follow his usual vocation and if so, please state:

(a) The nature of deformity, injury in brief, disease or illness which contributed to the causes leading to disability:

(b) What in your opinion caused the patient s disability?

(c) The percentage of disability:

(d) The time required for him to recover fully from the disability:

VI. Have you any information or remarks to make concerning the ailments, habits or mode of living of the patient which may have a bearing on the disability:

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

Date: Signature:

Place: Name of the Doctor/Hospital:

Address: