## LIFE INSURANCE CORPORATION OF INDIA

Divisional Office:

Claim Form : AD(PS)-1 Branch Office:

<del>-</del>	ander Asha Deep policy No
(Note: This form sh	hould be completed by the Life Assured)
1) Full Name : Address :	
2) i) Give details of paralytic stroke	
(a) Date of stroke:	////
(b) Reason:	
(c) Limbs affected :	
(d) No.of days for which completely functionless :	
ii) Are you, 1) Unable to walk: Yes /	No
2) Can walk with support	t : Yes I No
3) Can walk normally: Y	'es / No
iii) a) Whether movement of you is/are restricted? : Yes	ur arm(s)  I No
b) If Yes, state the parts (Reply to Question(s) 2 (ii) & (ii this form.)	affected.:  ii) above should be the information as on the day of filling up
3) Whether you had paralytic stroke earlier  If Yes give details of  (a) Date of attack: ////	r?:Yes I No
(b) Diagnosis:	
(c) Treatment availed:	
4) Whether you have suffered in the past Transient- Ischemic attack, Head injury, Injury, Hypertension, Diabetes, Heart Dis or other ailments resulting into paralytic a	Spinal sease
5) If yes, Give full details and name of the consulted in connection with paralytic Strand/or other ailment in the past, including the current episode.:	roke
Name & Address Date/s and detailsof Co	onsultation
1) Medical Attendant:	
2) Medical Specialist:	
6) If you were treated in a Hospital please	e give following details:
i) Name & Address of the Hospital/Medical Centre:	
Tel. No:	
ii) Date of Admission : ///	
iii) Date of Discharge:///	
Please furnish	
<ul> <li>i) all reports of investigations car scan Plate(s), Blood report(s)</li> <li>ii) Hospital discharge card(s)</li> <li>iii) All follow up report(s)</li> <li>(If any report(s) is/are not submitt</li> <li>7) Do you have any other Asha Deep Pol</li> </ul>	

Policy Date of Sum Servicing LIC No. Commencement Assured Branch Office Not withstanding the provisions of any law, usage, custom or convention for the time being in force prohibiting any physician or Hospital from divulging any knowledge or information acquired by him/them in attending upon or examining a person on the ground of secrecy, I hereby authorize the Physician or Hospital who has attended upon or examined or treated me for any ailment or illness to divulge any knowledge or information regarding my state of health which he/they may have acquired whether before or after the policy was issued by the Corporation, to the Corporation, its offices and legal advisors or in any court of law.

Name & Signature of witness

Signature / thumb impression of the Life Assured

Designation:

If the claimant signs in vernacular or affixes thumb impression, the witness should also sign the following declaration:

Address:

Certified that the contents of this form were explained to the declarant in vernacular and he/she has affixed his/her signature/thumb impression hereto after fully understanding the same.

Signature of witness.