**(Revised – 2006)**

LIFE INSURANCE CORPORATION OF INDIA

Division _____ Branch Office _____

## DEFORMITY QUESTIONNAIRE

Name of the proponent / Life Assured_____ Age _____Years

**Questions to be answered by the proponent's / policyholder's Personal Medical Attendant / Medical Examiner regarding Deformity/ies and / or Impairment/s**

| | | |
|---|---|---|
| 1. | a. What is the cause of deformity?<br>Whether it is<br><br>i. Congenital<br>ii. Due to an accident or injury<br>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:<br><br>i. What was the disease leading to deformity?<br>ii. When did it occur?<br>iii. Whether the disease is stationery or progressive?<br>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 | |
| 5 | 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 he /she 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<br><br>i. mild<br>ii. moderate<br>iii. severe | |

| | | |
|---|---|---|
| 11. | How many limbs are affected? | |
| 12 | Are there any respiratory complications?<br>If yes, give details | |
| 13 | Is there any restriction in movement of any of the fingers?<br>Are any of the fingers removed?<br><br>If so, upto which phalanx.<br>Whether thumb and forefinger have been affected / removed? | |
| 14 | a. Whether he / she can lift articles without any difficulty and hold the articles without losing the grip (in case of deformity in the hands)?<br><br>b. Is the grip firm and strong? | |
| 15 | Are there any residual complications? | |

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:

a. He / she is able / not able to perform routine self-care activities.

b. He / she is / is not required to use wheel chair / crutches.

c. Any other factors which are likely to add to the risk on account of the deformity / ies.

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 Examiner / Medical Attendant**
**Code No.**
**Qualifications**
**Registration No.**
**Address**