LIFE INSURANCE CORPORATION OF INDIA

FILARIASIS FORM

Additional Queries to be answered by the Medical Examiner in cases where a Proposer has a past or present history of Filariasis or Elephantiasis.

Full Name of the Life to be Assured_____ Age _____

1. Has the proposer ever suffered from or is now suffering from attacks of the diseases known as Filariasis, Lymphangitis, Chyluria or Elephantiasis?	
2. If so, state the variety of the disease: (a) Whether it is Filariasis with an inflammatory swelling and redness of the skin, fever and pain, with mild or severe constitutional disturbance and whether of one or more limbs of the upper or lower extremities. (b) Whether it is of the scrotum and/or penis (if a male) or of the external organs of generation (if a female) (c) Whether there has been any ulceration or discharge of foul matter (or lymph) from the ulcerated skin, at any time. (d) Whether there has been any passage of milky fluid known as Chyle (Chyluria), or a mixture of blood and chyle (Haematochyluria) from urine, and if so, when, for how long and how often.	
3. State the date of the first and last attacks, the number and frequency of the recurrent attacks, whether mild or severe and their duration.	
4. Give the approximate size, whether large or small and the circumferential measurements of the swelling in cms at its thickest and thinnest part.	
5. Since how many months or years have the attacks CEASED COMPLETELY and has there been any perceptible increase in the size of the swelling during the last two or three years?	
6. Are the swellings of such size as to interfere materially with the freedom of easy movements, exercise and daily work?	
7. Can the proposer submit a certificate from his usual medical attendant, testifying to a complete cessation and absence of even a single attack during the last three or five years.	

I Certify that the proposer / Life Assured has put his / her signature alongside in my presence

_____

Signature of the Proposer

_____

Signature of Agent/Development Officer
Name:
Code No.

_____

Signature of the Medical Examiner
Name & Qualification
Code No.

Place:
Date: