(Revised – 2006)

LIC
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? Whether it is i. Congenital ii. Due to an accident or injury 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: i. What was the disease leading to deformity? ii. When did it occur? iii. Whether the disease is stationery or progressive? 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 i. mild ii. moderate iii. severe	

11.	How many limbs are affected?	
12	Are there any respiratory complications? If yes, give details	
13	Is there any restriction in movement of any of the fingers? Are any of the fingers removed? If so, upto which phalanx. 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)? 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