Form No.5280(A)

LIFE INSURANCE CORPORATION OF INDIA

DIVISIONAL OFFICE____________________ **BRANCH OFFICE**________________

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

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{Questionnaire to be completed by the Doctor / Hospital who / which treated the life assured for his ailments / injuries / disability}

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1. (i) Name of the Patient in full ________________________
   (ii) Apparent Age ________________________
   (iii) Occupation ________________________
   (iv) Full Address ________________________
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   (v) Marks or physical peculiarities for purposes of identification ________________________

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2. (i) Consultation / Admission (a) Date ____________________
   (b) Time ____________________
   (c) Place ____________________
   (ii) Exact history reported at the time of consultation / admission ____________________
   (iii) Who reported the history ____________________

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3. 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 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? ____________________

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4. (i) Treatment ____________________
   (ii) Particulars of treatment given ____________________

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5. (i) What is the condition of the patient at present? ____________________
   (ii) Did you consider that the patient is now incapacitated and cannot follow his usual vocation and if so, please state ____________________

(a) Nature of deformity, injury in brief,
disease or illness which contributed
to the cause 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 ______________________

* (iii) Whether the patient is in a position to do any of the following Activities of Daily Living (given below) permanently without any help/support including the use of mechanical equipment, special devices or other aids.

(a) Dressing: (ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are medically necessary) ____________

(b) Washing: (ability to wash to maintain an adequate level of cleanliness and personal hygiene) ____________

(c) Feeding: (ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available) ____________

(d) Toileting: (ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene) ____________

(e) Mobility: (ability to move indoors from room to room on level surfaces at the normal place of residence) ____________

(f) Transfering: (ability to move from a bed to an upright chair or wheel chair and vice versa) ____________

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

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

Date: ____________ Signature ____________

Place: ____________ Name of Doctor / Hospital ____________

Address: ______________________ Reg. No. ____________

______________________ Seal of Doctor/Hospital

* Applicable for plans including LIC's Accidental Death and Disability Benefit Rider with DOC on or after 03.01.2014