ANNEXURE D

LIFE INSURANCE CORPORATION OF INDIA

Divisional Office _____ Branch Office _____

Claim for Disability/Sickness Benefit under Nav Prabhat Plan
Questionnaire on EARNING TEST
(To be completed by the Medical Attendant of the Life Assured)

Policy No. : _____ Claim No. : _____
Name of Patient : _____ Age : _____
Address:
_____
_____
_____

1. Since how long are you the medical attendant of the life assured?

2. When did the life assured first consult you regarding the disability ? (dd/mm/yy)

3. What according to you is the cause of disability?

4. What is the nature of disability/sickness at the time of diagnosis? Please provide details of disability with organs affected and extent of disability

5. What is his/her present condition? Please specify organs affected/and the extent of incapacitation.

6. Can the Life Assured sufficiently do/follow any work, occupation or profession so as to obtain any wages, compensation or profit? If not, please provide clarification.

7. In your professional opinion, do you consider the disability as permanent and irrecoverable.

8. a) Was the Life Assured treated for disability by any other medical practitioner/s or any Hospital before you were consulted ? If so, please state their names and address

b) Did any other Medical Practitioner/s Treat the Life Assured for disability in consultation with yourself ? If so, please state their names and addresses

I confirm that the information provided above are true to the best of my knowledge.

_____ _____
Signature or thumb impression of the Life Assured before Medical Attendant

Signature of Medical Attendant

Name of the Medical Attendant:
Registration No:
Address :

Date : _____
Place :_____ Telephone Number: _____