



**FUTURE
GENERALI**

TOTAL INSURANCE SOLUTIONS

DEFORMITY QUESTIONNAIRE

TO BE FILLED BY LIFE INSURED

Name of the Life Insured _____
 Application Number _____

PLEASE PROVIDE FOLLOWING DETAILS ABOUT LIFE TO BE INSURED

1. Have you ever suffered from any deformity or are you currently suffering from any deformity? Yes No

2. Reason of deformity and its duration:

- | | |
|---|--|
| <input type="checkbox"/> Congenital | <input type="checkbox"/> Accident |
| <input type="checkbox"/> Injury- Spine/Head/Tendon/Muscle/Nerve | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Palsy, Paralysis or Wasting or any Neurological Disorder | <input type="checkbox"/> Leprosy |
| <input type="checkbox"/> Bone Infection - Limb/Spine/Other Parts of the Body | <input type="checkbox"/> Amputation - Specify Reason _____ |
| <input type="checkbox"/> Disease - (Specify) _____ | <input type="checkbox"/> Others - (Specify) _____ |

If the deformity is due to an accident or trauma or any underlying disease, please state the following:

- What was the disease leading to the deformity? _____
- When did it occur? _____
- Whether the disease (disability) is stationary or progressive? _____
- If stationery, since when? _____
If others, please specify: _____

3. Part of body affected and severity: _____

Describe in detail the exact part/s of the body that are affected and severity of the impairment: _____

How many Body Parts / Limbs are affected? _____

Date of occurrence: _____

Nature of disability:

- | | |
|--|---|
| <input type="checkbox"/> Parts of body affected | <input type="checkbox"/> Shortening or angulations or deformity (Spine/Rib, etc.) |
| <input type="checkbox"/> Loss of limb-Left/Right/Both: a. Upper Limb b. Lower Limb | <input type="checkbox"/> Blindness- Total/Partial |
| <input type="checkbox"/> Hearing loss - Total / Partial | <input type="checkbox"/> Deaf and dumb |
| <input type="checkbox"/> Weakness or paralysis of limbs/part of body | <input type="checkbox"/> Others (Specify) _____ |

4. Treatment details: _____

Date: _____ Doctor/Hospital name: _____

Tests carried out: _____

Treatment details and findings: _____

- | | | |
|---|------------------------------|-----------------------------|
| 1. Any abnormality while walking - limp, hobble, stagger or cannot walk briskly or run? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Any apparent weakness in limbs; like unable to lift weight, clutch objects, etc? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are you using aid; like clippers, clutches wheel chair? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Are there any involuntary movements or palsy or paralysis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Any abnormality in speech/hearing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Any abnormality in Vision?* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Any numbness, tingling or throbbing sensation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Any abnormality in joints? Shoulder, elbow, hip, knee, neck - stiff, locked, wasting of soft tissues, pain, etc.
Can he/she squat, sit and get up properly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

9. Any abnormality in acknowledging sensations like decreased or no sensation? Whether he/she can lift articles without any difficulty and hold the articles without losing the grip (in case of deformity in the hands)? Is the grip firm and strong? Yes No
10. Any symptoms of uncontrollable leaking of urine from the bladder or bowel movement? Yes No
11. Is there any restriction in doing activity of daily living, like dressing, transferring, toileting, feeding, etc. without assistance? Yes No
12. Is the deformity progressive or static? Yes No
13. Have you been diagnosed with Parkinson's, Alzheimer or Multiple Sclerosis or any other neurological disorder? Yes No
14. History of Osteoarthritis or Rheumatoid arthritis or any other heart ailment? Yes No
15. Is there any disease of the skin or muscles like rash, ulcers, wasting or swelling? Yes No
16. Do you have Diabetes/ High Blood Pressure? Yes No
17. Did you ever suffer from epilepsy / seizures? Yes No

Please provide details if any, of the above questions that you answered as 'Yes'. _____

If the symptoms/limitations faced by you due to the disability does not fit any of the descriptions in the above table, please mention the details here:

5. Please provide complete name and address of your treating physician: _____
 _____ Date of last consultation: _____

6. Please provide any additional information, which you feel, will be helpful in processing your application:

7. Has your disability been examined by any of the government authorities? If yes, please share the disability certificate.
 I hereby declare and agree, that the above particulars and answers are complete and true, and this questionnaire will form part of the contract of the desired insurance on my life.

Place: _____

Date: _____ Signature of the Life Insured

* Please fill the questionnaire appropriately and submit the treatment papers.

VERNACULAR DECLARATION

I have explained the contents of this form and have read out the responses to the Life Insured in his/her local language. He/she has confirmed that the contents are fully understood by him/her.

Name of the Declarant: _____

Address of the Declarant: _____ Signature of the Declarant

Place: _____ Date: _____ Signature of the Life Insured