



MEDICAL QUESTIONNAIRE FOR TOTAL PERMANENT DISABILITY CLAIM

Policy No.		Claim No.	
DETAILS OF THE LIFE ASSURED			
Full Name of the Life Assured			
Age		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
A. DETAILS OF ILLNESS			
Symptoms/Complaints			
Duration of Symptom/Complaint			
Date of First Consultation			
Name & Address of Doctor Consulted			
Date of Event			
Event leading to main claim event and documentation of the same (FIR etc)			
Diagnosis Date			
B. DETAILS OF FAMILY DOCTOR			
Name of the Doctor			
Address			
Contact Nos.			
Email address			
C. NAME AND ADDRESS OF THE DOCTORS WHO HAD ATTENDED / THE HOSPITALS WHERE THE LIFE ASSURED WAS TREATED DURING LAST FIVE YEARS			
Name of Doctor/Hospital	Address	Date of Consultation	Diagnosis
D. IN CASE OF TPD DUE TO ACCIDENT			
Brief details of accident (with Reg. No. of vehicles involved)			
Was the Life Assured Driving vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please provide copy of Driving License)		
Date & Time of accident		Place of accident	
Name, address & Tel No. of the hospitals where the Life Assured was admitted after the accident			
Name, Address & Tel. Nos. of police station where accident was reported			

E. Total and Permanent disability clause

The Life Assured will be regarded as Totally and Permanently disabled if, as a result of accidental bodily injury, resulting solely and directly from an accident caused by outward, violent and visible means

No.	Particulars	Yes/No	Comments
i.	Whether the Life Assured has been rendered totally incapable of being employed or engaged in any work or any occupation whatsoever for remuneration or profit.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ii.	Whether the Insured has suffered the loss of (or the total and permanent loss of use of) both hands, or both feet, or both eyes, or a combination of any two.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
iii.	Whether the above Disability has been lasted without any interruption for at least 180 consecutive days.	<input type="checkbox"/> Yes <input type="checkbox"/> No	

F. Any additional information which could help us process the claim (To be filled in by the medical practionser only)

Please attach records along with this form.

I hereby declare that the information provided above is best to my personal knowledge & belief and nothing has been concealed therefrom.

Name Signature & Seal
Registration No
Address

Contact No. Date