IndiaFirstLife

Disability Questionnaire

Appl No: ☐☐☐☐☐☐☐☐☐☐ **Policy no:** ☐☐☐☐☐☐☐☐☐☐

Name of life to be Assured: F I R S T ... L A S T ... **Age:** ________

1. Date of Diagnosis: ________

2. Was it caused because of an Accident ☐ Polio ☐ or other illness? ☐

Give details ________

3. What is the exact nature of disability at present?

____

4. Date of last consultation with the Doctor: ________

Provide Name and Address of Treating Consultant: ________

5. Are you currently under treatment for this condition? Yes ☐ No ☐

If yes: Give Details along with treatment and consultation reports:

____

6. Does the above condition affect your bowel movement or bladder control? Yes ☐ No ☐

If yes: Give Details ________

7. Do you have any breathing problems? Yes ☐ No ☐

If yes: Give Details along with treatment and consultation reports:

____

8. Do you use any of the following as an aid for walking such as

Crutches ☐ Braces ☐ Calipers ☐ Wheelchair ☐ Walker ☐ None ☐

9. Do you make use of any other aid for any locomotive purpose? Yes ☐ No ☐

If yes: Please give the details ________

I declare that the answers to the above question are true and completed and shall form the part of an application with IndiaFirst Life Insurance Company Limited for insurance on my life.

________ ________

Signature of SP / Agent / BDM / ABH RBH or ZBH Signature of life to be Assured.

Date: D D M M Y Y Y Y Date: D D M M Y Y Y Y

Place: ________ Place: ________

IndiaFirst Life Insurance Company Ltd.,
12th and 13th Floor, North [C] Wing, Tower 4, Nesco IT Park, Nesco Center,
Western Express Highway, Goregaon (East), Mumbai – 400063,
CIN: U66010MH2008PLC183679.

Tel: +91 22 6165 8700 **Fax:** +91 22 6857 0600 **Toll Free:** 1800-209-8700
E-mail: customer.first@indiafirstlife.com **Website:** www.indiafirstlife.com