OPTHALMIC QUESTIONNAIRE

[To be filled by the medical examiner]

Application No: _____

Full Name of life to be assured: _____

1) Mention the actual number of glasses (+ve) or (-ve). _____

2) Does he / she has myopia? Yes ☐ No ☐

Right Left

3) If yes, what is the number of the glasses in each eye? _____ / _____

4) Is myopia: Stationary ☐ Progressive ☐

5) Is there any evidence of corneal opacity with visual loss? Yes ☐ No ☐

6) Are pupils normal in size, shape and reaction to light and accommodation? Yes ☐ No ☐

7) In your opinion are there any changes of:

a) Diabetic Retinopathy Yes ☐ No ☐

b) Hypertensive Retinopathy Yes ☐ No ☐

c) Any other abnormality Yes ☐ No ☐

I hereby agree that the forgoing questions and answers shall form pa rt of the proposal fo r insurance made by me to the Company.

Date: _____

Place: _____

_____

Signature of the life to be assured/Proposer