GENERALI Central
LIFE INSURANCE

Deformity Questionnaire

(To be filled by Life Insured)

Name of the Life Insured	
Application Number	

1. Please provide following details about life to be Insured:

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

2. Reason of deformity and its duration:

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

   _____

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

   i. What was the disease leading to the deformity? _____
   ii. When did it occur? _____
   iii. Whether the disease (disability) is stationary or progressive? _____
   iv. 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:

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

   _____

4. Treatment details: _____

   Date: _____ Doctor/Hospital name: _____

   Tests carried out: _____

   Treatment details and findings: _____

Sr. No.	Please answer the following questions [Tick (✓) the applicable]	Yes	No
1.	Any abnormality while walking - limp, hobble, stagger or cannot walk briskly or run?	☐	☐
2.	Any apparent weakness in limbs; like unable to lift weight, clutch objects, etc?	☐	☐
3.	Are you using aid; like clippers, clutches wheel chair?	☐	☐
4.	Are there any involuntary movements or palsy or paralysis?	☐	☐
5.	Any abnormality in speech/hearing?	☐	☐
6.	Any abnormality in Vision?*	☐	☐
7.	Any numbness, tingling or throbbing sensation?	☐	☐

Sr. No.	Please answer the following questions [Tick (✓) the applicable]	Yes	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?	☐	☐
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?	☐	☐
10.	Any symptoms of uncontrollable leaking of urine from the bladder or bowel movement?	☐	☐
11.	Is there any restriction in doing activity of daily living, like dressing, transferring, toileting, feeding, etc. without assistance?	☐	☐
12.	Is the deformity progressive or static?	☐	☐
13.	Have you been diagnosed with Parkinson's, Alzheimer or Multiple Sclerosis or any other neurological disorder?	☐	☐
14.	History of Osteoarthritis or Rheumatoid arthritis or any other heart ailment?*	☐	☐
15.	Is there any disease of the skin or muscles like rash, ulcers, wasting or swelling?*	☐	☐
16.	Do you have Diabetes/ High Blood Pressure?*	☐	☐
17.	Did you ever suffer from epilepsy / seizures?*	☐	☐

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: _____ _____

Dated: _____ 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