Form No.5279

LIFE INSURANCE CORPORATION OF INDIA

Divisional Office..

Branch Office..

Re: Claim for Disability Benefit

(Questionnaire to be completed by the Life Assured claiming Disability Benefit)

I. 1. Name in full of the Life Assured:

2. Present Age:

3. Occupation Prior to accident :

4. Full Address:

5. Particulars of policies held

	Policy No.	Sum Assured	Name of Office Servicing the policy
(a)			
(b)			
(c)			
(d)			

II. 1. Nature of disability & parts of the body affected:

2. Date from which you are disabled:

3. Describe in brief the circumstances under which you were disabled. Mention the date, time & place of the incident as a result of which you were incapacitated:

4. (a) If the disability arose as a result of an accident state the name of the Police Station to which the accident was reported, mentioning the Police Case No and date (Attach a copy of the Final Police Investigation Report certified by the Police Authorities)

(b) If the accident was not reported to the police, state the reasons therefor. Mention the full names, addresses and your relationship with two persons who might have witnessed the incident:

5. (a) Mention the nature of injuries received and the parts of the body affected:

(b) State the names of the Doctor/s Hospital/s who/which treated you for the ailments/injuries/disablement:
Note: Attach certificate issued by the doctor/s, hospital/s in regard to the treatment for ailments/ injuries/ disablement.

6. Mention your present vocation:

I.. do hereby declare that the foregoing statements are true and correct to the best of my knowledge.

Dated at........................... this.......................day of..................... 20..................

Signature/Thumb Impression of Life Assured.
Name of Life Assured:

Signature of Witness:

Name:

Designation:

Address: