FORM NO.SPQ 001

Life Insurance Corporation of India
_____Division

Branch Code _____

Proposal No_____

CONSULTING/FAMILY PHYSICIAN'S REPORT

NOTE: PART ONE AND PART TWO OF THIS REPORT ARE TO BE COMPLETED BY THE CONSULTING/FAMILY PHYSICIAN. THE REPLIES ARE TO BE ASCERTAINED FOR THE LIFE TO BE ASSURED, WHERE REQUIRED, BEFORE COMPLETING THE REPORT.

PART ONE (TOBACCO/SMOKING & ALCOHOL HABIT)

1. Full name of life to be assured (Surname first) **Age** **Sex**

2. Name and address of family physician

3. Has the life to be assured in the past consulted a specialist for
- **(a) Heat ailment?**
- **(b) Hypertension?**
- **(c) Diabetes?**

(answer 'yes' or 'No')

If specialist has been consulted, give his name and address.

4. Has he/she ever (I) used tobacco in any form?
(ii) taken alcoholic drinks?

IF ANSWER TO QUESTION 4(I) IS 'YES' REPLY QEUSTION 5 AND/OR 6.

5. TOBACCO/SMOKING HABIT

(a) Past habit

If he has stopped using tobacco, give

Approx. date of Stopping	No. of years of using tobacco	Quantity used per day

(b) Current habit

If he still continues to use tobacco, give

Tobacco used in which form	No. of years using tobacco	Qty used per day

6. ALCOHOL HABIT

(a) Past habit

If he has stopped taking alcohol, give

Approx. date of Stopping	No. of years of taking alcohol	Qty taken per day

(b) Current habit

If he still continues to take alcohol, give

Type of alcoholic drink	No.of years of taking alcohol	Qty taken per day

Date **Signature of consulting/family physician**

Place **Qualification**

Name **Reg. No.**

DECLARATION

I hereby authorize Dr…….to give to LIC of India any and all information he may have regarding my condition when under examination or observation and treatment by him including history obtained and diagnosis.

I hereby declare that the statements and answers to questions in Part One of this report are true and complete and I do hereby agree and declare that these will form part of the Proposal dated…….. given by me to LIC of India.

Signature of Life to be assured.

(TO BE SIGNED IN THE PRESENCE OF THE CONSULTING/FAMILY PHYSICIAN COMPLETING THIS REPORT)