

Eye Sight Supplementary Statement

INSTRUCTIONS FOR FILLING UP THE FORM:-

1. This form is to be filled by the **Ophthalmologist** himself/herself in BLOCK LETTERS in blue ink.
2. Please tick a box thus where appropriate.
3. Please strike out parts, which are not applicable and write 'N.A.'. Strokes of the pen, dots and dashes will not be accepted as replies.
4. Form filling person must affix his/her full signature for any cancellation/correction/alteration.
5. Form filling person must affix his/her full signature on each page / side of the form.

(This statement should be completed by Ophthalmologist)

Application Number:

Date:

Proposal Number:

Life Assured's Name:

Proposer

Date of Birth : _____

Please answer each question and where appropriate provide particulars.

Right

Left

1. What is the present state of vision? :-
 Power of lens / glasses :- _____

2. What is the nature of his refraction?
 Hypermetropia, myopia etc. :- _____

3) a) If Myopia how long has he wearing glasses? :- _____
 b) Is the Myopia, progressive or stationary? :- _____

4) Describe the condition of media :- _____

5) a) Has any cataract? :- Yes / No
 b) If 'Yes', which side? :- Right / Left
 c) Is it mature or not? :- Yes / No

6) a) Are iris and pupil normal? :- Yes / No
 b) If 'No', describe the abnormality :- _____
 c) State papillary reaction :- _____

7) a) Is there any squint? :- Yes / No
 b) If 'Yes', paralytic or non-paralytic? :- _____

8) a) Did he have any eye operation? :- Yes / No
 b) If 'Yes', give details :- _____

9) a) Is the funds normal? :- Yes / No
b) If 'No', describe in detail the abnormality and its significance. :- _____

I, _____(Medical Examiner) hereby declare and solemnly affirm that I have conducted all tests as per standard requirements and diagnostic techniques on _____ after due verification of his identity on the basis of driving license/passport/_____. Results/findings herein have been obtained as per the standard guidelines, diagnostic techniques /testing procedures.

I further affirm that nothing has been misrepresented or concealed by me. I understand that this declaration is significant since the findings herein are relevant for assessment of risk by the company and shall form part of the contract between _____ Proposed Assured and the company and also that the Proposed Assured has consented to and permitted disclosures herein made.

Place : _____
Date : _____
Address : _____

Signature of Ophthalmologist

Contact No. : _____
Registration No. : _____

Stamp of the Doctor

Place : _____
Date : _____

Signature of Life Assured

Please enclose self attested copy of all past & present medical records including Investigation reports.