CLAIM FORM NO.CIRB 11

CRITICAL ILLNESS (Aorta graft surgery)
FORM TO BE FILLED BY LIFE ASSURED

Branch : **Divisional Office :**

Policy number
Claim number
Name of the Life Assured
Date of birth of the Life Assured
Address

_____

1. When did you have the symptoms for the first time ?

2. What symptoms did you feel , please give exact details Eg, Chest pain, low back pain, mid abdominal pain, giddiness, perspiration, breathlessness, High BP, hypotension,etc

3. How long did the symptoms last ?

4. What is the exact diagnosis of your condition?

5. Please give details of all consultations and investigations done and dates on which they were performed. Eg Chest xray, abdominal xray, USG, CT scan, MRI, Aortography, etc.

Consultation details/Name of the test Dates

6. Have you undergone Aorta graft surgery ? If yes, please provide details :

Date of surgery :

Name of the hospital where surgery was performed :

Details of surgery/corrective procedure:

Was stenting done? if yes, please provide details :

Location of the surgery (abdominal/thoracic) . Please give details of the vessels grafted including Branches Reason for surgery : (Aortic aneurysm/dissection/any other please specify)

7. Did you have any previous hypertension, hypotension,heart disease, angina, vascular disease, diabetes, atherosclerosis, Marfan s syndrome, syphillitic aortitis or any other disease? If yes, please give details of diagnosis , dates of diagnosis and treatment.

8. Do you suffer from any congenital heart disease ? If yes, please provide details.

9. Were you required to be away from work due to heart ailment? If yes, please give details of dates and duration of time off work?

10. Do you or have you smoked/used tobacco products? If yes, please give details of the type and daily consumption.

11. Name and address and telephone numbers of the hospital/hospitals where the treatment was given/ surgery performed.

12. Names and addresses of specialists/ surgeons consulted

13. Please provide any further information which may be of assistance to us in assessing the claim.

Kindly submit the original reports of all investigations and Operating Surgeon s report,
Consultant s reports, all blood test reports, Chest xray, abdominal xray, USG, CT scan, MRI, Aortography, Hospital discharge summary, follow up reports and any other reports available with you.

I_____ hereby declare that the statements made above are true and complete. I authorise
the medical attendant, hospital, physician who has/have treated or examined me for any ailment or illness to divulge any information regarding my health known to them either in the past or present to LIFE INSURANCE CORPORATION and its officers.

Signature of the Life Assured:

Date Place
_____

Signature of the witness:

Name of the witness :

Address of the witness :