CLAIM FORM NO.CIRB 12

CLAIM UNDER CRITICAL ILLNESS RIDER
(Aorta Graft Surgery)
(To be filled by Medical Attendant/Cardiologist)

Claim Form : CIR(Aorta Graft surgery)

Divisional Office: Branch Office :

Re : Aorta Graft surgery Claim under CIR Policy No._____
Fvg._____

(Note : This form should not be given to anyone in person but sent directly to the Divisional Office in self-addressed envelope)

1) Since how long are you the Life Assured s
Medical Attendant?

2) Give details of the treatment :

i) Date of first consultation :

ii) Nature of the symptoms:

iii) Duration of symptoms :

iv) Final Diagnosis :

v) Date of diagnosis:

3) Whether the life assured had a past history of 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.

4) Particulars of investigations and surgery undergone alongwith dates performed. Eg Chest xray, abdominal xray, USG, CT scan, MRI, Aortography, etc

Consultation details/Name of the test Dates

5) Details of life assured s illness :

6) Please give complete details of treatment.

7) Has the insured undergone Aorta graft surgery ? If yes, please provide details :

Was an aortography performed before the surgery? If yes please enclose report.
Date of surgery :

Reason for surgery : (Aortic aneurysm/dissection/any other please specify)
Name of the hospital where surgery was performed :

Details of surgery/corrective procedure:

No of grafts performed :

Vessels repaired/replaced (including branches)
Location of the surgery (Abdominal/thoracic) :

Was stenting done? if yes, please provide details :

Name and address of the Hospital where the procedure was performed.

Name of the specialist performing the procedure.

8) Did the life assured suffer from any congenital heart disease ? If yes, please provide details.

9) When did the life assured have the first symptoms/signs suggestive of heart/aortic disease?

10) Has there been any previous associated disease/s?. If yes, please give details.

11) Are you aware of his/her smoking habits?. If yes, please provide details.

12) Has there been any history of cardiovascular disease in the patient s family i.e parents, brothers or sisters? If yes, please provide details.

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 of the life assured available with you.

I hereby declare that the above statements are true and complete to the best of my knowledge.

Signature of the Medical Attendant/Cardiologist.

Date :
Place :

Name :
Regn. No. :
Qualification :
Address :
Tel.No.: