CLAIM FORM NO.CIRB 13

CRITICAL ILLNESS (Blindness)
FORM TO BE FILLED BY LIFE ASSURED

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

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1. When were the symptoms of decreasing vision first noticed ?

2. Dates of first consultation

3. Date of diagnosis

4. Has both eyes been affected? If yes, please give details of degree of loss of vision in each of the eyes.
5. If blindness is due to illness, please provide the following information:

(i) Cause of blindness

(ii) Did you suffer from any of the following : Diabetes/Multiple Sclerosis/Retinal Detachment/Optic Neuritis/hypertension/any other?

(iii) If yes , please give details of date of diagnosis of the above, investigations done, treatment and follow up

6. If blindness occurred due to accident, please provide the following information

(i) When did the accident occur ? Date Time

(ii) How and where did it occur ?

(iii) Was police complaint registered? If yes, please provide copies of FIR, police investigation reports and any newspaper information of accident

(iv) Was any other person involved/present during the accident? If yes, please inform the names, addresses and relationship of the persons who were present.

7. Were you hospitalised ? If yes, please give details

Name of the hospital

Date and time of admission

Treatment details

Date and Time of discharge

8. Please provide details of all consultations and investigations done and dates on which they were performed eg. blood tests, xray and investigations done by opthalmologist/neurologists, etc...

Consultation details / Name of tests Dates

9. Give details of the treatment including any surgery.

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

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

12. 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 Ophtalmologist report, Operating Surgeon s report, Consultant s reports, all blood test reports, xray, Hospital discharge summary, follow up reports and any other reports available with you. If the cause is due to accident, please also provide copies of FIR/police reports.

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 :

DECLARATION

Note : This should only be completed if the Life Assured with illness is unable to complete the form himself due to total blindness.

On behalf of the ______________________ (the Life Assured), I __________________ (name and relation to the Life Assured) do hereby declare that the statements made hereinabove are true and complete in each and every respect.

On behalf of the Life Assured, I authorise the Hospital and Doctors who have examined or treated the Life Assured for any ailment or illness to provide information regarding the illness which may have been acquired before or after the policy was issued by LIFE INSURANCE CORPORATION OF INDIA to the Corporation and its Offices.

I also agree to provide and furnish details and reports as and when required by LIFE INSURANCE CORPORATION OF INDIA for processing the claim.

Date : Signature of the declarant

Place : Name of the declarant

Address of the declarant

Telephone number

Signature of the witness:

Name of the witness :

Address of the witness :

(The declaration must be witnessed by persons authorised to witness by LIC, (you can for eg say Advocate, bank manager, Block Development officer, gazette Officer, Magistrate, etc..)