CLAIM FORM NO.CIRB 14

CLAIM UNDER CRITICAL ILLNESS RIDER (Blindness)
(To be filled by Medical Attendant/Opthalmologist)

Claim Form : CIR(Blindness)

Form No.
Divisional Office: Branch Office :

Re : Blindness 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) Are you the Life Assured s Medical Attendant? If yes, how long do you know the patient?

2) When did the life assured first consult you and what was the nature of consultation?

3) What was the history of the case before admission as informed to you?

4) What according to you is the likely cause of blindness?

5) Have both eyes been affected? If yes, please give details of degree of loss of vision in each of the eyes. (L/R)

6) Is loss of vision in both eyes

a) Permanent? Yes/No

b) Reversible? Yes/No

7) If the blindness is due to illness, please provide the following information:

(i) Cause of blindness

(ii) Did the life assured 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

8) If blindness is due to accident, please provide the following information

(i) When did the accident occur?
(ii) How and where did it occur ?
(iii) Was a police complaint regarding accident registered before the admission?

9) Please provide details of all consultations and investigations done and dates on which they were performed eg. blood tests, xray, etc .

Consultation details/Name of tests Dates

10) Give details of the treatment including any surgery

11) Do you have any reason to believe that the cause could be due to self inflicted injury?

12) Particulars of investigations and surgery undergone alongwith dates performed.
Eg blood tests, xray, and investigations done by opthalmologist.

Consultation details / Name of the test Dates

14) Names and addresses of specialists/ surgeons/opthalmologist/neurologists consulted.

15) Are you aware of any history of psychiatric illness of the life assured? If yes, please provide details of the date of occurrence, diagnosis and treatment details.

16) 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, Opthalmologist s report, Consultant s reports, all blood test reports, xray, ECG, 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.

Date :
Place :

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