CLAIM FORM NO.CIRB 15

CRITICAL ILLNESS (Third Degree Burns)
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 did the accident occur ? Date Time

2. How and where did it occur ?

3. What was the cause of burns ? (Thermal/electric/chemicals)

4. Which parts of the body are affected? Please provide details.

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

Name of the hospital
Date and time of admission
Date and Time of discharge
Treatment details

6. What was the severity of burns as diagnosed by the doctor ? (First degree/Second degree/third degree), if known

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

8. Give details of the treatment including any surgery/blood transfusions done

9. Was police complaint registered before hospitalisation? If yes, please provide with copies of FIR and police reports.

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

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

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

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, xray, Hospital discharge summary, follow up reports and any other reports available with you. Also please provide copies of FIR and 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 :