CLAIM FORM NO.CIRB 17

CRITICAL ILLNESS (MAJOR ORGAN TRANSPLANT)
FORM TO BE FILLED BY LIFE ASSURED

Re: Claim form for _____ organ transplant.

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

Address
_____

1. When were the symptoms first noticed ?

2. What was the nature of the symptoms ?

3. Please state the duration of the symptoms.

4. Please state which organs have been affected.

5. Dates of first consultation

6. Date of final diagnosis

7. Exact diagnosis of your condition.

8. When were you advised for a transplant ?

9. What was your health status prior to the transplant ?

10. Have you ever been diagnosed as below? If yes, please state the details:

Date of diagnosis Treatment details

· Diabetes
· Hypertension
· Kidney disease

11. Please state the date of onset of organ failure

12. Is the organ failure end stage ?

13. If the transplant is for kidney failure, please answer the following :

Are both kidneys affected ?
Are you undergoing renal dialysis? (Yes/No)
If yes, please provide details

· Date of first dialysis :
· Frequency of dialysis : _____ Times per week
· Mode of dialysis : Peritonial /Hemo
· Name, address and telephone number of hospital/medical centre where the dialysis is done

14. Please give details of all consultations , and investigations and dates on which they were performed. Eg serial blood tests, Xray, Ultrasonography, Scanning/IVP), Biopsy, Tissue typing, follow up of relevant blood tests, serum drug levels, any other.

Consultation details/Name of the test Dates

15. Please provide details of treatment

Treatment details Dates of treatment Name of hospital

16. Have you undergone organ transplant ? Yes/No

If yes, Please give details

(a) Date of transplantation/s
(b) Is the donor related/unrelated/cadaver
(c) Number of transplants
(d) Details of immunosuppresants
(e) Condition of the scar

17. If the above is no , are you included in the official waiting list of an organ transplant? If yes, please provide details.

18. Did/Does the transplant involve stem cell transplants? If yes, please provide details.

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

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

21. Does any of your family members, parents, brother, sister etc have a history of organ failure? If yes, please provide details.

22. Name and address and telephone numbers of the hospital/hospitals where the treatment was given.

Name of the hospital :
Address of the Hospital:
Telephone number of the hospital

_____

Name of the hospital :
Address of the Hospital:
Telephone number of the hospital

_____

23. Names and addresses of specialists/ surgeons consulted
Name of the operating surgeon/specialist
Address :
Telephone number

_____

Name of the operating surgeon/specialist
Address :
Telephone number

_____

24. 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, Hospital discharge summary, specialist report,biopsy, tissue typing ,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 :