

CLAIM FORM NO.CIRB 18

CLAIM UNDER CRITICAL ILLNESS RIDER (Major Organ Transplant)
(To be filled by Medical Attendant)

Claim Form : CIR(MOT)-1

Divisional Office:

Branch Office :

Re : Transplant of _____ .Claim under CIR Policy

No. _____

Name of the Life assured _____

(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) When were the symptoms first noticed ?
- 3) What was the nature of the symptoms ?
- 4) Please state the duration of the symptoms
- 5) Date of first consultation
- 6) Date of final diagnosis
- 7) Exact diagnosis of the patient s condition
- 8) What was the health status of the patient prior to transplant ?
- 9) Has the patient ever been diagnosed as below? If yes, please state the details:

Date of diagnosis

Treatment details

- Diabetes
- Hypertension
- Kidney disease

10) Please state the date of onset of organ failure.

11) Is the failure considered

- Acute or chronic ?
- Reversible or irreversible?
- End stage or compensated ?

12) If the transplant is for kidney failure, please answer the following :

Are both kidneys affected ?

Is the failure end stage ?

Is the life assured undergoing renal dialysis? (Yes/No)

If yes, please provide details

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

13) Please provide details of all 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.

Name of the test

Dates

Results

14) Please provide details of treatment

Treatment details

Dates of treatment

Name of hospital

15) Did the patient undergo organ transplant ? Yes/No
If yes, Please give details

1. Date of transplantation/s

2. Is the donor related/unrelated/cadaver?

3. Number of transplants

4. Details of immunosuppressants

5. Condition of the scar

16) If the above is no, is the patient included in the official waiting list of an organ transplant? If yes, please provide details.

17) Did/does the transplant involve stem cell transplants? If yes, please provide details.

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

19) Has there been any history of organ failure in the patient's parents, brothers or sisters? If yes, please provide details.

20) 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 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 :