CLAIM FORM NO.CIRB 19

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

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 the cause of paralysis? (Illness/injury)

5. Is the condition due to external injury ? If yes, please provide details.

6. Date of first consultation

7. Date of final diagnosis/confirmation of paralysis.

8. Exact diagnosis of your condition. Please also give details of the limb/side affected and number of days for which the limbs are completely functionless.

9. Please give details of all consultations , and investigations and dates on which they were performed. Eg CT scanning, MR imaging, ECG tracings, Xray reports and any other investigations. Please note that evidence of permanent neurological evidence must be suppported by appropriate evidence such as CT/MRI angiography.

Consultation details/Name of the test Dates

10. Is there a past history of stroke or any related illness like hypertension, angina, transient ischaemic attacks, head injury, spinal injury, meningitis, encephalitis, diabetes or any other vascular disease(s)?

If yes, please provide details of

Date of diagnosis

Details of treatment

11. Please provide details of treatment such as medication (tablets, injections, anticoagulents), surgical therapy, supportive therapy, physiotherapy, any other

Treatment details Dates of treatment Name of hospital

12. Are you now able to
Speak? (yes/no)

Walk? (yes/no)

Walk with support ?(yes/no)

Walk normally without support ?(yes/no)

13. Is the movement of your limb/limbs now restricted? If yes,please state which parts are affected.

14. 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?

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

16. Does any of your family members, parents, brother, sister etc have a history of stroke /paralysis/ any neurological disease? If yes, please provide details.

17. 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
_____

18. Names and addresses of specialists/ surgeons/physiotherapists consulted

Name of the operating surgeon/specialist

Address :

Telephone number
_____

Name of the operating surgeon/specialist

Address :

Telephone number
_____

19. 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, neurologist s report, physiotherapist s report, 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 neurological deficits.

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..)