**CLAIM FORM NO.CIRB 20**

**CLAIM UNDER CRITICAL ILLNESS RIDER (Paralysis)**
**(To be filled by Medical Attendant/Neurologist)**

Claim Form : CIR(P)-1

Divisional Office: Branch Office :

Re : Paralysis 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) Since how long are you the Life Assured s
Medical Attendant?

2) Please provide the following details :

i) Date of onset of the symptoms :

ii) Nature of the symptoms:

iii) Duration of symptoms :

iv) Date of first consultation

v) Precise Diagnosis of the condition:

vi) Date of diagnosis/confirmation of paralysis:

vii) Exact cause of paralysis : (brain injury at birth/tumours arising in the brain or spinal cord/ traumatic injury to the brain or spinal cord/ infections such as poliomyelitis, diptheria, untreated syphilis, encephalitis, etc/ motor neurone disease/ any other cause). Please provide details.

3) Please provide the exact details of the evolution of paralysis and the prognosis

4) Please provide exact details of clinical neurological findings indicating etiology and associated diseases, if any.

5) Please also give the duration of the neurological sequelae which resulted into paralysis both pre-existing and co-existing conditions.

6) What is power in the upper and lower limbs presently ?

7) What is the percentage of disability ?

8) Is the disability permanent ? (yes/no)

9) Is he/she is able to walk with/without support?

10) Please provide details of all 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 neuro logical deficit must be suppported by CT/MRI scan.

Name of the test Dates Results

11) Please provide details of treatment such as medication (tablets, injection, anticoagulants), surgical therapy, supportive therapy, physiotherapy, any other

Treatment details Dates of treatment Name of hospital

12) Is there a past history of stroke or any related disease 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

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

14) Has there been any history of neurological disease in the patient s parents, brothers or sisters? If yes, please provide details.

15) 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 report, physiotherapist report, 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/Neurologist

Date : Name :

Place : Regn. No. :
Qualification :
Address :
Tel.No.: