CLAIM FORM NO.CIRB 3

CRITICAL ILLNESS (HEART ATTACK/CABG/HVR)

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 did you have the symptoms for the first time ?

2. What symptoms did you feel , please give exact details
Eg, Chest pain, giddiness, perspiration, breathlessness, High BP, etc

3. How long did the symptoms last ?

4. Please give details of all consultations and investigations done and dates on which they were performed. Eg ECG, cardiac enzyme tests, x ray, echocardiography, CTMT, Thallium scan, coronary angiography

Consultation details/Name of the test   Dates :

5. Did you have any previous hypertension, heart disease, angina, vascular disease, diabetes or any other disease. If yes, please give details of diagnosis, dates of diagnosis and treatment.

6. Have you history of Rheumatic Heart Disease. If yes, please provide details regarding date of diagnosis, duration and treatment.

7. Have you undergone any surgery/intervention such as CABG/PTCA/Heart Valve replacement/open heart surgery. If yes please give details of nature of surgery/intervention and dates of the procedure.

8. What is the exact diagnosis of your condition:

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

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

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

12. Names and address and telephone numbers of specialists/ surgeons consulted

13. Please provide any further information which may be of assistance to us in assessing the claim.

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 :

Note :

Kindly submit the original reports of all investigations and Operating Surgeon s report, Consultant s reports, all blood test reports, serial ECGs, serial enzyme reports, coronary angiography reports, 2 D echo reports, TMT reports, Hospital discharge summary, follow up reports and any other reports available with you