CLAIM FORM NO.CIRB 4

CLAIM UNDER CRITICAL ILLNESS RIDER
(To be filled by Medical Attendant/Cardiologist)

Claim Form : CIR(HA/CABG/HVR)-1

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Divisional Office: Branch Office :

Re : HA(MI)/CABG/HVR 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) Give details of the treatment :

i) Date of first consultation :

ii) Nature of the symptoms:

iii) Duration of symptoms :

iv) Final Diagnosis :

v) Date of diagnosis:

3) Whether the life assured had a past history of BP/Diabetes/Giddiness/Chest Pain/ vascular disease/ angina/hyperlipidaemia. If yes, please give details.

4) Particulars of investigations and surgery undergone alongwith dates performed.

Eg Serial ECGs, serial cardiac enzymes, x ray, Echocardiography, CTMT, Thallium scan, C.Angiography, CABG/PTCA, any surgery.

5) Details of Insured s illness :

6) Please give complete details of treatment.

7) When did the life assured have the first symptoms/signs suggestive of heart disease?

8) Has there been any previous associated disease/s. If yes, please give details.

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

10) Has there been any history of ischaemic heart disease in the patient s family i.e parents, brothers or sisters?

A) HEART ATTACK (MYOCARDIAL INFARCTION)

1) State the precise diagnosis : Acute Myocardial Infarction/ Angina

2) Was it associated with chest pain?

3) How was the diagnosis confirmed ?

(please enclose reports of serial ECGs and Cardiac Enzymes, etc..)

B) CORONARY ARTERY BY-PASS SURGERY

1) Was Angiography done before surgery :
(If yes, enclose report)

2) Type of surgical procedure :

3) Date of surgical procedure :

4) Name of the Hospital where the procedure was performed.

5) Name of the specialist performing the procedure.

6) If CABG was performed , state number of graft/s, by passed vessels details of coronary arteries corrected/bypassed :

7) If PTCA was performed, please give details :

8) Location/size/condition of scar :

C) HEART VALVE REPLACEMENT OR REPAIR

1) Was a 2 D echo with doppler done before surgery
(If yes, please enclose report)

2) Type of Surgical procedure :

3) Date of Surgical procedure :

4) Name the valves repaired/replaced :

5) Name of the Hospital where the procedure was performed.

6) Name of the specialist performing the procedure.

7) Did the LA suffer from Rhuematic Heart Disease. If yes, please provide details on when it was diagnosed and the treatment details.

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

I hereby declare that the above statements are true and complete to thebest of my knowledge.

Signature of the Medical Attendant/Cardiologist.

Date :

Name :

Place :

Regn. No. :

Qualification :

Address :

Tel.No.:

NOTE :

Kindly submit certified copies of reports, 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 of the life assured available with you