CLAIM FORM NO.CIRB 5

CRITICAL ILLNESS (CANCER)
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. Dates of first consultation

3. Date of diagnosis

4. Exact diagnosis of your condition. Please also give details of the site of tumour, malignancy, organ originated and other organs/lymph nodes involved

5. Is there a past history of tumour/cancer/HIV infection. If yes, please provide details of

Date of diagnosis

Details of treatment

6. Has there been any previous malignant (or premalignant) disease or conditions ?

If yes, please provide details.

7. Please give details of all consultations, and investigations and dates on which they were performed.
Eg. Blood reports, xray, Sonography/mammography/CTscan/MRI/Biopsy/FNAC/PAP smear
Consultation details / Name of the test Dates

8. Does any of your family members, parents, brother, sister etc have a history of cancer. If yes, please provide details.

9. Please provide details of treatment/surgery/ chemotherapy/radiation

Treatment details Dates of treatment Name of hospital

10. Have you been tested for HIV, If yes please inform the date of test and current HIV status.

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

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

13. Names and addresses of specialists/ surgeons/radiotherapists consulted

14. 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 OF INDIA 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 original reports of all investigations, histopathology reports/IHC Operating Surgeon s report, Consultant s reports, all blood test reports, Hospital discharge summary, follow up reports and any other reports available with you.