CLAIM UNDER CRITICAL ILLNESS RIDER FOR CANCER
(To be filled by Oncologist)

Claim Form : CIR(C)-1

Divisional Office: Branch Office :

Re : Cancer 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 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:

3) Please provide details of :

Site and size of tumour

Organ originated

Type of malignancy

Whether it is localised and non invasive

Other organs/lymph nodes involved.

Precise anatomical and Histopathological diagnosis with precise staging and grading of the lesion

HIV status

4) Whether the life assured had a past history of tumour / premalignant condition/HIV Infection. If yes,

please provide details of exact diagnosis and treatment details

5) Please give details of all consultations , and investigations and dates on which they were performed.
Eg Blood reports, x ray, Sonography/mammography/CT scan/MRI/Biopsy/FNAC/PAP smear
Name of the test Dates Results

6) Please give complete details of treatment.
Please provide details of treatment/surgery/ chemotherapy/radiation
Date of commencement of treatment:

Treatment details   Dates of treatment   Name of hospital

7) What is the present stage of cancer?

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

9) Has there been any history of cancer in the patient s family i.e parents, brothers or sisters?

        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 the best of my knowledge.

Signature of the Medical Attendant/Oncologist

Date :
                                                            Name :
Place :
                                                            Regn. No. :

                                                            Qualification :

                                                            Address :

                                                            Tel.No.:

NOTE :

**Kindly submit certified copies of 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 of the life assured available with you.**