CLAIM FORM NO.CIRB 8

CLAIM UNDER CRITICAL ILLNESS RIDER (STROKE)

(To be filled by Medical Attendant/Neurologist)

Claim Form : CIR(S)-1

Divisional Office: Branch Office :

Re : Stroke 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:

3) Is the condition due to infarction of brain tissue or intercranial bleeding as a result of external injury? If yes, please provide details of injury, exact diagnosis , date of diagnosis and treatment details

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 the exact details of the evolution since the stroke and the prognosis

11) 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 neurological deficit must be suppported by CT/MRI scan.

Name of the test Dates Results

12) 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) 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

13) Is there a past history of stroke, 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

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

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

16) 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/Neurologist

Date :

Name :

Place :

Regn. No. :

Qualification :

Address :

Tel.No.:

NOTE :

Kindly submit certified copies of reports of all investigations and Operating Surgeon s report, Consultant s reports, all blood test reports, Hospital discharge summary, neurologist s report, physiotherapist report, follow up reports and any other reports of the life assured available with you.