CLAIM FORM NO.CIRB 9

CRITICAL ILLNESS (KIDNEY FAILURE)
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. What was the nature of the symptoms ?

3. Please state the duration of the symptoms.

4. Dates of first consultation

5. Date of final diagnosis

6. Exact diagnosis of your condition.

7. What was your health status prior to the renal failure ?

8. Have you ever been diagnosed as below?. If yes, please state the details:

Date of diagnosis Treatment details

· Diabetes
· Hypertension
· Kidney disease

9. Please state the date of onset of renal failure

10. Are both kidneys affected ?

11. Please give details of all consultations , and investigations and dates on which they were performed. Eg serial Renal function tests, Xray (KUB), Ultrasonography, Scanning/IVP), Renal Biopsy, Tissue typing, follow up RFTs, serum drug levels, any other.
Consultation details/Name of the test Dates

12. Please provide details of treatment

Treatment details Dates of treatment Name of hospital

13. Are you undergoing renal dialysis (Yes/No) ?

If yes, please provide details

· Date of first dialysis :
· Frequency of dialysis : _____ Times per week
· Mode of dialysis : Peritonial /Hemo
· Name, address and telephone number of hospital/medical centre where the dialysis is done

14. Have you undergone kidney transplant ? Yes/No
If yes, Please give details

(a) Date of transplantation/s
(b) Is the donor related/unrelated/cadaver
(c) Number of transplants
(d) Details of immunosuppresants
(e) Condition of the scar

15. Were you required to be away from work due to this condition?. If yes, please give details of dates and duration of time off work?

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

17. Does any of your family members, parents, brother, sister etc have a history of renal failure or associated disease. If yes, please provide details.

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

19. Names and addresses of specialists/ surgeons/nephrologists consulted

20. 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, Hospital discharge summary, Nephrologist report, last /latest dialysis Certificate, dialysis Card ,follow up reports and any other reports available with you.