Critical Illness Claim Form: Heart Related Conditions

Medical Report – Confidential

Name of the Life Assured:_____

Date of Birth:_____

Address: _____

Policy Number: _____

The above named is insured against certain serious conditions. A lump sum is payable in the event of the applicant having been diagnosed as suffering from one of these conditions. A claim has been submitted to us advising us that the person insured has suffered a heart related condition. In order to enable us to assess the claim, we would appreciate it if you would complete this report and return it to us.

We would also be grateful for sharing copy of any reports that could assist our Medical Officers in their assessment of the claim (e.g. resting and exercise stress ECGs, cardiac enzyme results, isotope imaging, coronary and LV angiography, etc).

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1. General

a) Are you the patient's usual Medical Attendant? Yes / No
If 'yes', since when? If 'no', do you know who is? _____

a) When did the patient first have symptoms of heart disease?

_____

C) Has the patient ever had a past history of same disorder or a history of hypertension, diabetes, chest pain, hypercholesterolemia, angina or other vascular disease? Yes / No If 'yes', please give dates and details of consultations:

_____

_____

d) When you were first consulted for the disorder?

_____

e) What were the chief complaints and the duration of the symptoms?

_____

_____

f) What was the treatment given? Please provide complete details.

_____

_____

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_____

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_____

g) Were any investigations done? Was any Surgery done? (for eg : Serial ECG's, CTMT, Echo, Thallium, Coronary Angiography, CABG, PTCA, any other surgery).Please provide complete details with exact dates.

_____

_____

_____

_____

h) Is there any family history that would have increased the patient's risk of having coronary artery disease or suffering a heart attack?

_____

i) Are you aware of the patient's past and present smoking habits? Yes /No. If "Yes", please provide details, if known?

_____

j) Remarks and/or additional information (if any):

_____

_____

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

Signature and Seal of Medical Attendant / Cardiologist:

Name:
Registration No:
Qualification:
Address:
Telephone No:
Date & Place:

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2**) Disorder and Treatment: HEART ATTACK:**

a) Name and address of the hospital where the patient was treated:

_____

_____

b) Please provide the details of exact diagnosis, with date (For e.g: Acute Myocardial Infarct / NSTEMI /Angina etc). Also provide a detailed description of the condition at the time of admission.

_____

_____

_____

_____

c) Did the patient experience chest pain? Yes / No. If yes, please provide a full history of his condition:

_____

_____

_____

_____

d) How was the diagnosis confirmed? Please give details of all investigations performed and surgery done, if any, along with the dates. (For eg : measurement of cardiac enzymes, ECG, TMT, coronary angiography etc). A copy of these investigations would be appreciated.

_____

_____

_____

_____

_____

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e) Remarks and /or additional information (if any):

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

Signature and Seal of Medical Attendant/Cardiologist:

Name:
Registration No:
Qualification:
Address:
Telephone Number:
Date & Place:

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3. Disorder and Treatment : Coronary Artery By-Pass Surgery / Angioplasty :

a) Name and address of the hospital where the procedure / surgery was performed:

b) Name of the attending medical specialist:

c) Was Angiography done? Yes / No
If Yes, please mention the date it was done and the findings:

(Please also enclose a copy of the report)

d) Details of CABG surgery, if done: (For eg : Date of Surgery, Number of Graft/s, details of coronary arteries corrected, by passed vessels etc)

e) Details of Angioplasty, if performed: (For eg : Date of procedure, Number of stents, Coronary arteries corrected etc

f) Date of discharge and condition at discharge

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g) Remarks and/or additional information (if any):

_____

_____

_____

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

Signature and Seal of Medical Attendant/Cardiologist:

Name:
Registration No:
Qualification :
Address :
Telephone Number:
Date and Place:

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4. Disorder and Treatment :Open Heart Replacement or Repair of Heart Valves:

a). Name and address of the hospital where the procedure / surgery was performed

_____

_____

_____

b) Name of the attending medical specialist:

c) Did the patient has a past history of Rheumatic Heart Disease?

Yes/No If 'yes', please provide the following details:

Date of Diagnosis: _____

Treatment details:

d) Was a 2D echo with Doppler done? YES/NO

If Yes, please mention the date it was done and the findings:

_____

(Please also enclose a copy of the report)

e) Details of Surgery:

Type of Surgery performed:_____

Date of Surgery: _____

Valves repaired/replaced:_____

Was an open heart surgery undertaken? Yes / No

f) Remarks and/or additional information (if any):

_____

_____

_____

_____

_____

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

Signature and Seal of Medical Attendant / Cardiologist:

Name:

Registration No:

Qualification:

Address:

Telephone No:

Date & Place: