Critical Illness Claim Form: Chronic Lung Disease
Medical Report – Confidential

Name of Life Assured:____

Date of Birth:____

Address:____

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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 in the prepaid envelope provided. Please note that this form should not be handed over to anyone in person.

We would also be grateful for sharing copy of any reports that could assist our Medical Officers in their assessment of the claim.

1. General

A. Are you the patient's usual Medical Attendant? Yes / No

If 'Yes', since when?

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B. What is the underlying disease causing the patients lug failure and when was the underlying disease diagnosed?

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C. What were the symptoms and when did they first occur?

Symptoms presented at first consultation	Date Symptoms First Started (DD/MM/YYYY)

What is the source of this information: Patient / Referring Doctor / Others*

If Others*, please specify:____

D. When the patient did first consulted you for End Stage Lung Failure / Lung Disease?

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E. Has the patient ever had the same or a related condition? Yes / No
If "Yes", please give dates and details of consultations:

F. Does the patient suffer from any other disorder? If Yes, Please provide details.

Details of Disorder	Date of Diagnosis

G. Is there any family history that would have increased the patient's risk of suffering from lung failure?

H. Please give details on the patient's past and present smoking habits:

2. Disorder and treatment

A. Please state the exact diagnosis of the Life Assured's condition

B. Date when it was First Diagnosed. (DD/MM/YYYY) and by whom (Name of Doctor)

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C. Does the patient suffer from chronic and irreversible failure of both lungs?
Yes / No. If "Yes", Please provide exact date of diagnosis.

D. Were any investigations done to confirm the diagnosis? Yes / No. If Yes, please provide the details. (In case Pulmonary function tests done, please mention the dates and results, including FEV1 and vital capacity readings)

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E. Is the Life Assured Pao2 < 55 mmHG? Yes / No. If Yes, please provide the full details of arterial blood gas analysis results.

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F. Is the Life Assured under extensive and permanent oxygen theraphy for hypoxemia? Yes / No. If Yes, since when? DD/MM/YYYY

G. Is there dysponea at rest? Yes / No

H. Any other comments/ information on the client's condition?

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

Signature & Seal of Medical Attendant Name:

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

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