Critical Illness Claim Form: End Stage Liver Disease
Medical Report – Confidential

Name of Life Assured:_____

Date of Birth:_____

Address:_____

_____

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. 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? If 'No', do you know who is?

B. What is the underlying disease causing the patients liver disease and when was the underlying disease diagnosed? DD/MM/YYYY

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 Liver Disease?

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 End Stage Liver Disease?

_____

_____

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)

_____

_____

_____

C. Does the patient suffer from End stage Liver Disease? Yes / No.
If "Yes", Please provide exact date of diagnosis. DD/MM/YYYY

D. Were any investigations done to confirm the diagnosis? Yes / No.
If Yes, please provide the details.

_____

_____

_____

E. Does the patient currently have permanent Jaundice? Yes / No
If Yes,

_____

_____

F. Were there signs of hepatic encephalopathy? Yes / No
If "Yes", please provide full details.

_____

_____

G. Was there ascities? Yes / No
If "Yes", please provide how and when detected: DD/MM/YYYY

_____

_____

H. Was there presence of Esophageal or Gastric Varices and Portal Hypertension? Yes / No
If "Yes", please provide details of investigations done which revealed this?

_____

_____

I. Is the liver disease secondary to alcohol or drug abuse ? Yes / No
If "Yes", please provide full details:

_____

_____

J. Was any surgery performed? Yes / No
If "yes", please provide details.

_____

_____

K. Is the presence of any other illness? Yes / No
If " Yes", please provide the details.

_____

_____

L. Please provide names and addresses of any hospital which the Life Assured was treated/ admitted along with name of consultants who attended.

_____

_____

M. Please provide any additional information which will help in claims assessment.

_____

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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: