

III. Please tick (at least one) category / condition specifying the patient's ailment / Condition / Surgery

- | | | |
|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Major Organ Transplant |
| <input type="checkbox"/> Coronary Artery Bypass Graft | <input type="checkbox"/> Heart Valve Surgery | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Loss of Speech | <input type="checkbox"/> Medullary cystic disease |
| <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Loss of limbs |
| <input type="checkbox"/> End Stage Lung Disease | <input type="checkbox"/> Necrotising Fasciitis | <input type="checkbox"/> Brain Surgery |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Primary Pulmonary Hypertension | <input type="checkbox"/> Terminal Illness |
| <input type="checkbox"/> Major Burns | <input type="checkbox"/> Apallic Syndrome | <input type="checkbox"/> Aplastic Anaemia |
| <input type="checkbox"/> Motor Neurone disease | <input type="checkbox"/> Surgery of Aorta | <input type="checkbox"/> Major Head Trauma |
| <input type="checkbox"/> Loss of Independent Existence | <input type="checkbox"/> Coma | <input type="checkbox"/> Paralysis/Paraplegia |
| <input type="checkbox"/> End Stage Liver Disease | <input type="checkbox"/> Deafness | <input type="checkbox"/> Poliomyelitis |
| <input type="checkbox"/> Total and Permanent disability | <input type="checkbox"/> Multiple trunk avulsions of the brachial plexus | |
| <input type="checkbox"/> Benign Brain Tumour | <input type="checkbox"/> Systemic Lupus Erythematosus | |
| <input type="checkbox"/> Angioplasty and other invasive treatment for CAD | | |

IV. Other Information

Name and address of hospital where patient was admitted:.....

Date of Admission..... Date of Discharge

Any other information, which in your opinion will assist us in a assessing this claim? If "Yes", please give details below.....

I.....Medical Attendant of the Life Assured
do hereby solemnly declare that foregoing statements are true and correct to the best of my knowledge and belief.

Dated at.....this.....day of.....

Stamp of Medical Attendant

Signature of Medical Attendant.....
 Name of Medical Attendant
 Qualifications.....
 Phone number
 Mobile No.....Email ID.....