LIFE INSURANCE CORPORATION OF INDIA

(Operating Surgeon s Report)

Claim Form: AD (CABG)-3

Divisional Office: Branch Office:

Re: CABG Claim under Asha Deep Policy No._____
favouring _____
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(Note: This form should **NOT** be given to anyone in person but sent directly to the Branch Office in self-addressed envelope)

1) Particulars of life assured who underwent CABG:
   Name:
   Address:

2) When were you first consulted for the Heart ailment? : *I I*

3) Diagnosis of the Cardio-Vascular disease _____
   which led to CABG _____

4) Give details of operation:
   (a) Date of operation _____
   (b) No of grafts _____
   (c) No. of by-passed vessels _____
   (d) Details of grafting _____

5) Please give any additional information _____
   which will assist us in admitting _____
   the claim. _____

Date:
Place: Signature of the Operating Surgeon

Name:_____
Qualificaiton _____
Regn. No. _____