La Capitale

CLAIM FOR CHILDREN'S CRITICAL ILLNESS BENEFITS
Attending Physician's Declaration

Identification of the Insured

Name and address of the Insured ______________________________

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______________________________ Postal code

Tel.: (_____)______________________________ Home

Gender: F ☐ M ☐

Date of birth: ________-________-________ Year Month Day

Contract No.: ______________________________

I hereby authorize all information or files regarding the health of my insured child related to this claim be forwarded to the Insurer. A photocopy of this authorization shall be considered as valid as the original.

______________________________ Signature of insured child

______________________________ Date (year/month/day)

______________________________ Signature of father, mother or legal guardian (if the child is a minor)

______________________________ Date (year/month/day)

Attending Physician's Statement (Please print)

1. Please specify your diagnosis. ______________________________
2. When did your patient's symptoms first occur? ______-______-______ Year Month Day

   What did they consist of? ______________________________
3. a) On what date did your patient first consult you for this condition? ______-______-______ Year Month Day

   b) Was the patient referred to you? ☐ Yes ☐ No

   c) When did this person first become a patient of yours? ______-______-______ Year Month Day
4. Please provide the names and addresses of other physicians whom your patient consulted or hospitals where your patient received attention for this condition.

Last name	**Address**	**Date from** Year Month Day	**Date to** Year Month Day

5. Please provide us with any other information that you believe would be pertinent to the settlement of this claim.

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Please provide a copy of all available reports and test results on the diagnosis for use by our medical director.

Our contract requires that the diagnosis of a covered illness be made by a physician who is neither related to nor a business associate of the insured. Are you related to or a business associate of the insured? Yes ☐ No ☐

______________________________ Signature of attending physician

______________________________ Date

______________________________ Name and licence No. (Please print)

______________________________ Address

(THE CLAIMANT IS RESPONSIBLE FOR ANY FEES CHARGED FOR THIS REPORT)