CLAIM FOR CRITICAL ILLNESS BENEFITS
Attending Physician's Statement
Alzheimer's disease

Identifying information about the insured

Name and insured's the insured _____ Postal code

Gender: F ☐ M ☐

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

Contract No.:_____

Tel.: (_____)_____ Home

Tel.: (_____)_____ Work

Profession/occupation: _____

I authorize any physician and hospital to disclose all information related to this claim. A photocopy of this authorization shall be considered as valid as the original.

_____ Signature of insured

_____ Date

Attending Physician's Statement (Please print)

1. a) On what date did your patient first exhibit symptoms? _____-_____-_____ Year Month Day What were they?

_____

_____

_____

b) On what date did your patient first consult you for this condition? _____-_____-_____ Year Month Day

Was the first consultation with one of the patient's family members? If so, please indicate the date of that consultation.

_____-_____-_____ Year Month Day

c) How long has this person been a patient of yours? _____-_____-_____ Year Month Day

2. Please provide a summary of the clinical course, and briefly describe the patient's neurological signs and symptoms, **giving the dates and durations.**

_____

_____

_____

3. On what date was the diagnosis of possible Alzheimer's disease first discussed?

a) With the patient _____-_____-_____ Year Month Day

b) With the family _____-_____-_____ Year Month Day

(Reverse)

Attending Physician's Statement (cont.)

4. On what date was it determined that continuous daily supervision of the patient was necessary? _____-_____-_____
Year Month Day

5. Please provide:

a) A copy of the consultation reports and test results associated with the investigation of Alzheimer's disease.

b) The names and addresses of other physicians who were consulted or hospitals to which the patient was admitted for this condition.

_____

_____

_____

c) The name and address of the neurologist who confirmed the diagnosis.

_____

_____

6. Does the patient have a family history of Alzheimer's disease?

_____

_____

7. Does the patient have any other significant family history?

_____

_____

8. a) Does your patient use any form of tobacco or marijuana including cigarettes, cigarillos, cigars or a pipe or a tobacco substitute such as a nicotine patch or gum? ☐ Yes ☐ No

b) If yes, indicate the quantity or number per day: _____

c) How long has your patient used these products? _____

d) If no, has your patient used one of these products in the past? ☐ Yes ☐ No

e) When did your patient cease using it? _____-_____-_____
Year Month Day

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

_____

_____

_____

_____

Please provide a copy of your consultation notes, specialist or hospital reports, recent X-rays, test and investigation reports, laboratory data and clinical results.

Our contract requires that the diagnosis of a covered illness be made by a physician who is not a relative or a business associate of the insured. Are you a relative 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)