CLAIM FOR CRITICAL ILLNESS
Attending Physician's Statement - Cancer

Insured's Identification

Name _____ Sex: F ☐ M ☐

Address of _____ Date of Birth: _____-_____-_____
of Year Month Day
the Insured _____
Postal code Policy No: _____

Tel.: (_____) _____ Occupation: _____
Home

Tel.: (_____) _____
Work

I hereby authorize the release to my Insurer of any information INCLUDING CONSULTATION REPORTS with respect to this claim. A photocopy of this authorization has the same value as an original.

_____ _____
Patient's Signature Date

Physician's Statement

1. a) On what date did your patient first have symptoms? _____-_____-_____
Year Month Day

What were they? _____

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

c) How long has this person been your patient? _____-_____-_____
Year Month Day

2. a) Please provide the date this cancer was diagnosed: _____-_____-_____
Year Month Day

b) On what date was the patient advised of the diagnosis: _____-_____-_____
Year Month Day

By whom? _____

3. **<u>Please provide a copy of the pathology report</u>** giving the following details:

- Type of Tumour
- Site of Tumour
- Clinical Stage T N M
- Histology and Staging

Physician's Report (Cont'd)

4. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer:

Name	**Address**	**Date from** (year, month, day)	**Date to** (year, month, day)

5. a) Has your patient previously suffered from cancer or any predisposing disorders? If so, please provide dates and details.

_____

_____

b) Has your patient ever been tested for the Human Immunodeficiency Virus?

☐ Yes ☐ No ☐ I don't know

_____ _____ _____ Result: _____
Year Month Day

6. a) Does your patient smoke cigarettes, cigarillos, cigars or a pipe or use any form of tobacco or marijuana or a 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) Dans 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

7. a) Is there a family history of cancer? Please provide details.

_____

_____

b) Please provide details of any other significant family history.

_____

8. Please provide any other information that would be helpful in the assessment of your patient's claim.

_____

_____

Please provide copies of any specialist or hospital reports for our Medical Director's review

Our policy requires that a covered illness be diagnosed by a physician who is not related to or in a business relationship with the insured. Are you related to or in a business relationship with this patient? Yes ☐ No ☐

_____ _____
Signature of Attending Physician Date

_____ _____
Name and License No (Capital Letters) Address

(THE PATIENT IS RESPONSIBLE FOR THE REQUIRED FEES FOR THIS REPORT)