CLAIM FOR CRITICAL ILLNESS BENEFITS
Attending Physician's Statement
Coma

Identifying information about the insured

Name and _____ Gender: F ☐ M ☐

insured's _____ Date of birth: _____-_____-_____
Year Month Day

address _____
Postal code

Contract : _____

Tel.: (_____)_____ Profession/occupation: _____
Home

Tel.: (_____)_____
Work

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) Was the coma caused by an accident ☐ an illness ☐ or another cause ☐ ? Please provide details:

_____

_____

_____

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

c) When did the symptoms first appear? _____

d) Since what date has the insured been your patient? _____-_____-_____
Year Month Day

2. Please describe the events that caused the coma.

_____

_____

_____

3. How long has the patient been in a coma? _____

4. What tests have been done to determine the depth of the coma? **Please provide us with the test results.**

_____

_____

_____

5. Please describe in detail anything in the patient's lifestyle or medical history that might have increased the risk or contributed to the medical condition.

_____

_____

_____

(Reverse)

La Capitale

Attending Physician's Statement (cont.)

6. Is there a family history of a related medical condition? Please provide details:

_____

_____

_____

7. 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

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

_____

_____

_____

9. Please provide the names and addresses of other physicians who were consulted or hospitals to which the patient was admitted for this condition.

_____

_____

_____

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 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)