CLAIM FOR CRITICAL ILLNESS BENEFITS
Attending Physician's Statement
Coronary Artery Bypass Surgery

Identifying information about the insured

Name and address of the insured _____ Postal code

Gender: F ☐ M ☐

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

Contract No.: _____

Profession/occupation: _____

Tel.: (_____)_____ 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) When did your patient first exhibit symptoms or suffer from cardiovascular disease? Please provide details in that regard.
_____-_____-_____ Year Month Day _____

_____

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

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

2. Please provide the observations concerning the preoperative angiography or a copy of the report.

_____

_____

3. Please provide a copy of the surgical report, if any, or provide information on the aortocoronary bypass surgery.

a) Date of surgery: _____-_____-_____ Year Month Day

b) Which arteries were involved? _____

_____

c) Name and address of the hospital and name of the cardiovascular surgeon:

Name	**Address**	**From** (year, month, day)	**To** (year, month, day)

(reverse)

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. Box 16040, Quebec QC G1K 7X8

Attending Physician's Statement (cont.)

d) Name and address of the cardiologist who recommended the bypass surgery:

Name	**Address**	**Telephone No.** (including area code)

4. Please describe and provide dates for any of the patient's risk factors for cardiovascular disease, including genetic predisposition.

_____

_____

_____

_____

5. Please provide the names and addresses of other physicians whom your patient consulted or hospitals where your patient received attention with regard to this condition or a related one.

Name	**Address**	**From** (year, month, day)	**To** (year, month, day)

6. Does the patient have a family history of cardiovascular or cerebrovascular disease? Please provide details in that regard.

_____

_____

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

_____

_____

Please provide copies of any specialist or hospital reports for use by our medical director.

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)