CLAIM FOR CRITICAL ILLNESS BENEFITS
Attending Physician's Statement
Heart attack (myocardial infarction)

Identifying information about the insured

Insured's name _____ Gender: F ☐ M ☐

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

_____
Postal code

Contract No.: _____

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

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

2. a) Was a diagnosis of myocardial infarction made? Yes ☐ No ☐

b) Date of the diagnosis: _____-_____-_____
Year Month Day

c) Name of the physician who made this diagnosis: _____

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

_____

3. Please provide the following details pertaining to your patient's heart attack:

a) Description of chest pain: _____

_____

_____

b) Date symptoms were first experienced: _____-_____-_____
Year Month Day

c) Electrocardiographic changes at the time of the attack or copies of pertinent ECG tracings: _____

_____

(Reverse)

Attending Physician's Statement (cont.)

d) Details of changes in myocardial marker enzymes at the time of the attack: _____

_____

4. Details of any other investigations (dates and reports): _____

_____-_____-_____
Year Month Day

5. Please provide dates and details of when your patient first suffered symptoms or episodes of cardiovascular disease?

_____-_____-_____ _____
Year Month Day

_____-_____-_____ _____
Year Month Day

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

_____

_____

7. Do you know if any of the patient's family members have suffered from this condition or a similar condition? If yes, please provide details:

_____

_____

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 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 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)