CLAIM FOR CRITICAL ILLNESS BENEFITS
Attending Physician's Statement
Kidney Failure

Identification of the insured

Name and address of the insured _____ Postal code

Gender: F ☐ M ☐

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

Contract No.: _____

Tel.: _____ Home

Profession/occupation: _____

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.

_____ Claimant's Signature

_____ 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) When did your patient first exhibit symptoms or suffer from kidney disease or impaired renal function? _____-_____-_____ Year Month Day

   Please provide details in that regard. _____

   _____

3. a) Is your patient in the terminal phase of irreversible kidney failure involving both kidneys?

   _____

   b) What is the cause of the kidney failure?

   _____

   _____

   c) On what date did your patient begin receiving dialysis? _____-_____-_____ Year Month Day

   d) Does your patient receive regular renal dialysis? Yes ☐ No ☐

   e) Has kidney transplant surgery been performed or proposed for the future? Yes ☐ No ☐

4. Please provide us with the results of any relevant investigations and laboratory tests.

5. Please describe any genetic predisposition or risk factor for kidney disease, such as diabetes or hypertension, with which your patient has presented and provide dates.

   _____

   _____

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Attending Physician's Statement (cont.)

6. a) Does the patient have a family history of kidney disease? Please provide details in that regard.

_____

_____

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

_____

_____

7. Please provide the names and addresses of other physicians whom your patient consulted with regard to this condition.

Name of physician or hospital	**Address**	**From** (year, month, day)	**To** (year, month, day)

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 any other information that may be useful to us when examining your patient's 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)