La Capitale

CLAIM FOR CRITICAL ILLNESS BENEFITS
Attending Physician's Statement
Multiple sclerosis

Information about 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) On what date did your patient first exhibit symptoms? What were they? _____-_____-_____ (Year Month Day)

_____

_____

_____

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

c) When did this person first become a patient of yours? _____-_____-_____ (Year Month Day)

2. Please provide a summary of the clinical course, and briefly describe the patient's neurological signs and symptoms, **giving the dates and durations of flare-ups.**

_____

_____

_____

3. On what date was the diagnosis of possible multiple sclerosis first discussed? _____-_____-_____ (Year Month Day)

4. Please provide:

a) A copy of the imaging report confirming the diagnosis.

b) The names and addresses of other physicians who were consulted or hospitals where your patient received attention with regard to this condition.

Physician or hospital name	**Address** *(No., Street, City, Province, Postal Code)*	**From**			**To**		
		Year	Month	Day	Year	Month	Day

c) The name and address of the neurologist who confirmed the diagnosis.

Name of the neurologist	**Address** *(No., Street, Town/City, Province, Postal Code)*	**Telephone No.** ***(including area code)***
		( ) --

(reverse)

Attending Physician's Statement (cont.)

5. Does the patient have a family history of multiple sclerosis?

_____

_____

6. Does the patient have any significant family history?

_____

_____

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.

_____

_____

_____

_____

_____

_____

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)