CLAIM FOR CRITICAL ILLNESS BENEFITS
Attending Physician's Statement
Parkinson's disease

Information about 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.

_____ 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.**

_____

_____

_____

3. Does your patient require substantial physical assistance from another adult to perform the following activities of daily living:

Bathing?	☐ Yes	☐ No	Dressing?	☐ Yes	☐ No
Toileting?	☐ Yes	☐ No	Continence?	☐ Yes	☐ No
Transferring?	☐ Yes	☐ No	Eating?	☐ Yes	☐ No

4. On what date was the diagnosis of possible Parkinson's disease first discussed? _____-_____-_____ Year Month Day

(reverse)

La Capitale

Attending Physician's Statement (cont.)

5. Please provide:
   a) A copy of the consultation reports and test results associated with the investigation of your patient's condition.
   b) The names and addresses of other physicians who were consulted or hospitals where your patient received attention with regard to this condition.

   _____

   _____

   _____

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

   _____

   _____

6. Does the patient have any significant family history?

   _____

   _____

7. Does the patient have any other significant family history?

   _____

   _____

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 so, indicate the quantity or number per day: _____

   c) How long has your patient used these products? _____

   d) If not, 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 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 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)