CLAIM FOR CRITICAL ILLNESS BENEFITS
Attending Physician's Statement
Stroke

Information about the insured

Name and address of the insured _____ Postal code

Gender: F ☐ M ☐

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

Contract No.: _____

Tel.: (_____)_____ Home

Tel.: (_____)_____ Work

Profession/occupation: _____

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

2. a) Date symptoms were first experienced: _____-_____-_____ Year Month Day

   b) Description of initial symptoms: _____

3. Date of first visit for this condition: _____-_____-_____ Year Month Day

4. a) Is there paralysis or other neurological deficits? Yes ☐ No ☐

   b) If so, please specify the neurological sequelae: _____

5. Duration of paralysis or neurological deficit: from _____-_____-_____ Year Month Day to _____-_____-_____ Year Month Day

6. Are the neurological sequelae temporary? ☐ permanent? ☐

7. To your knowledge, have there been other consultations and/or hospital stays for the same symptoms, in the weeks or months leading up to this stroke? If yes, please specify.

(reverse)

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. Does your patient have any risk factors of stroke?

	YES	NO	Since when?	Medication
Hypertension	☐	☐	_____-_____-_____ Year Month Day	_____
Tobacco use	☐	☐	_____-_____-_____ Year Month Day	_____
Dyslipidemia	☐	☐	_____-_____-_____ Year Month Day	_____
Diabetes	☐	☐	_____-_____-_____ Year Month Day	_____

10. Name of any other physician whom the insured has consulted or any hospital where the insured has received treatment for this condition or a related one:

_____

_____

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 review 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)