NATIONAL BANK LIFE INSURANCE COMPANY

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Physical Illnesses

Note: For psychological illnesses, complete the form on the reverse

Original request

Loan or credit card information

Insured – CIS No. ______ Transit No. ______

	Loan or card number		Loan or card number	
☐ Personal loan				
☐ Mortgage loan				
☐ Commercial loan				
☐ Auto-Choice loan				
☐ MasterCard credit card		→ The claim concerns ☐ Cardholder ☐ Insured spouse		→ The claim concerns ☐ Cardholder ☐ Insured spouse

IDENTIFICATION OF THE INSURED

Surname ______ Date of birth (YYYYMMDD) ______

Given name ______ Sex ☐ M ☐ F Social insurance number ______

Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: ______

1.2 Secondary: ______

1.3 Complications: ______

1.4 For the illnesses or associated symptoms diagnosed, has the patient previously:

a) received medical treatments ☐ b) consulted another physician ☐ c) taken drugs ☐ d) been hospitalized ☐ e) undergone examinations ☐

Specify the periods: ______

1.5 Is the disability related to: an accident ☐ an illness ☐ an occupational accident ☐ an automobile accident ☐

Date of the event: Y Y Y Y M M D D

a pregnancy No ☐ Yes ☐

a preventive withdrawal from work No ☐ Yes ☐ Scheduled date of delivery: Y Y Y Y M M D D

1.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.

At the beginning of disability: Y Y Y Y M M D D Currently

2. Treatment

2.1 Drugs – name – dosage: ______

2.2 Has the patient undergone or will undergo:

a) examinations or tests No ☐ Yes ☐ Specify: ______

b) surgery No ☐ Yes ☐ Day surgery ☐ Type: ______

Surgical procedure: ______ → Date: Y Y Y Y M M D D

c) other treatments No ☐ Yes ☐ Specify: ______

d) hospitalization: from ______ to ______ Name of hospital: ______

d) a short stay under observation No ☐ Yes ☐ Number of hours: ______

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Dates of other consultations: ______ Follow-up frequency: ______

3.3 Referral to another physician: No ☐ Yes ☐ Name of physician: ______

Specialty: ______

3.4 Approximate duration of disability: No. of days ______ No. of weeks ______ Unspecified ☐ or date of return to work Y Y Y Y M M D D

3.5 How long before the patient will be able to return to work? No. of days ______ No. of weeks ______

part-time ☐ full-time ☐ gradual return ☐ Specify: ______

4. Questions specific to the contract

4.1 In the past five (5) years has the patient consulted a health care professional, had a medical examination or follow-up, suffered or been diagnosed with or treated for any of the following problems: heart disease or circulatory disorders, blood disorders including cholesterol, blood pressure disorders, tumours or cancer, muscular dystrophy, multiple sclerosis, AIDS, Human Immunodeficiency Virus or any other disease or disorder of the immune system, chest pains or angina, lung disease or respiratory problems, digestive problems, liver disorders, intestinal disorders, kidney disease, urinary tract disorders, genital disorders, nervous system disorders, diabetes, fibromyalgia or chronic fatigue syndrome, neck, back or spinal column disorders, muscle, joint or bone problems or psychiatric or psychological disorders.

No ☐ Don't know ☐ Yes ☐ If yes, please supply the following information:

Diseases	Dates	Results/Treatments	Hospitalization periods	When was the patient informed about the disease?

4.2 ______

5. Identification of the physician

5.1 Family name, given name: ______ Telephone: ( )

5.2 License number: ______ Fax: ( )

General practitioner ☐ Specialist ☐ Specify: ______

Signature: ______ Date: Y Y Y Y M M D D

13893-512 (06-2002)

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM

NATIONAL BANK LIFE INSURANCE COMPANY

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Psychological Illnesses

Note: For physical illnesses, complete the form on the reverse

Original request

Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: ______

1.2 Secondary: ______

1.3 Current symptoms: ______

1.4 Degree of severity of all symptoms: Mild ☐ Moderate ☐ Severe ☐ With psychotic elements ☐

1.5 Does the interruption of work result from problems related to:

☐ marital/family life ☐ loss of employment or layoff ☐ professional problems

☐ personal or interpersonal problems ☐ alcohol or drug abuse or gambling problems

☐ other problems, specify: ______

1.6 For the illnesses or associated symptoms diagnosed, has the patient previously:

a) received medical treatments ☐ b) consulted another physician ☐ c) taken drugs ☐ d) been hospitalized ☐ e) undergone examinations ☐

Specify the dates of previous episodes: ______

2. Treatment

2.1 Drugs – name – dosage: ______

2.2 Is the patient consulting: a psychiatrist No ☐ Yes ☐ a social worker No ☐ Yes ☐

a psychologist No ☐ Yes ☐ another health care provider No ☐ Yes ☐

If Yes, name of the caregiver consulted: ______

2.3 Hospitalization: from ______ to ______ Name of hospital: ______

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Dates of other consultations: ______

3.3 Follow-up frequency: ______

3.4 Will the patient be referred to a psychiatrist? No ☐ Yes ☐ Name of physician: ______

3.5 Approximate duration of disability: No. of days ______ No. of weeks ______ Unspecified ☐ or date of return to work Y Y Y Y M M D D

3.6 How long before the patient will be able to return to work? No. of days ______ No. of weeks ______

part-time ☐ full-time ☐ gradual return ☐ Specify: ______

4. Questions specific to the contract

4.1 In the past five (5) years has the patient consulted a health care professional, had a medical examination or follow-up, suffered or been diagnosed with or treated for any of the following problems: heart disease or circulatory disorders, blood disorders including cholesterol, blood pressure disorders, tumours or cancer, muscular dystrophy, multiple sclerosis, AIDS, Human Immunodeficiency Virus or any other disease or disorder of the immune system, chest pains or angina, lung disease or respiratory problems, digestive problems, liver disorders, intestinal disorders, kidney disease, urinary tract disorders, genital disorders, nervous system disorders, diabetes, fibromyalgia or chronic fatigue syndrome, neck, back or spinal column disorders, muscle, joint or bone problems or psychiatric or psychological disorders.

No ☐ Don't know ☐ Yes ☐ If yes, please supply the following information:

Diseases	Dates	Results	Hospitalization periods	When was the patient informed about the disease?

4.2 ______

5. Identification of the physician

5.1 Family name, given name: ______ Telephone: ( )

5.2 License number: ______ Fax: ( )

General practitioner ☐ Specialist ☐ Specify: ______

Signature: ______ Date: Y Y Y Y M M D D

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM