

Declaration by Attending Physician

IDENTIFICATION OF INSURED

Insured – CIS No.	Transit No.	Loan No.
Surname at birth	Date of birth	
First name	Sex	Social Insurance Number
	<input type="checkbox"/> M <input type="checkbox"/> F	

DECLARATION OF ATTENDING PHYSICIAN

In order for a claim request relating to cancer to be accepted under the terms and conditions of this insurance policy in the event of a critical illness, it must satisfy the following conditions.

Cancer means a diagnosis by a Physician authorized to practise and practising medicine in a Canadian province, of a malignant tumour characterized by the uncontrolled enlargement and spread of malignant cells and the invasion of tissue. This includes leukaemia and Hodgkin’s disease.

The following forms of cancer and conditions are not covered :

- Cancer in situ;
- Skin cancer except malignant melanoma affecting the skin less than 0,7 mm deep;
- Stage A prostate cancer (T1N0M0);
- Any tumour if Human Immunodeficiency Virus (HIV) is present;
- Any other benign, pre-cancerous or non invasive tumour;
- All cancer relapses or all metastatic tumours that appeared during the 90-day exclusion period.

1. a) When did the patient first show symptoms? Y M D
|_|_|_|_|_|_|_|_|

Describe the symptoms and provide details.

b) Date of first consultation for this condition : Y M D
|_|_|_|_|_|_|_|_|

c) How long have you been treating this patient? Y M D
|_|_|_|_|_|_|_|_|

2. a) When was cancer diagnosed? Y M D
|_|_|_|_|_|_|_|_|

b) Specify the type of cancer : _____

c) What was used to diagnose the cancer (e.g. MRI, CAT scan)?

d) When was the patient informed of the diagnosis? Y M D
|_|_|_|_|_|_|_|_|

e) Who notified the patient? _____

3. Please provide a copy of the pathology reports complete with the following information :

- type of tumour _____
- location of tumour _____
- histology and staging _____

CONTINUE OVERLEAF

4. Please list the names and address of any other physicians consulted by the patient or hospitals where he or she received treatment for this cancer.

Name of physician or hospital	Address (No., Street, City, Province, Postal code)	From (year, month, day)	To (year, month, day)																								
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5. a) Has the patient ever had cancer or a health-related problem that may have contributed to his/her illness?

Yes No

If so, please provide dates and any relevant information.

b) Has the patient been tested for Human Immunodeficiency Virus (HIV)?

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6. a) Does the patient have a family history of cancer, diabetes, stroke or heart disease before the age of 60? Please provide details.

b) Please provide information on any other major illness in the family.

7. Please provide details of the patient's use of tobacco, including the quantity consumed daily, as well as the date when he stopped using tobacco.

8. Please include any other relevant information that could be useful in assessing the patient's claim request.

Please attach copies of any report prepared by a specialist or hospital for examination by our medical expert.

SIGNATURE OF THE ATTENDING PHYSICIAN

Name and address (please print) : _____

Specialty _____

Telephone No. ()

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SIGNATURE _____ DATE

Y	M	D

The patient is responsible for completing this form and assuming any applicable costs.