

Declaration by Attending Physician

IDENTIFICATION OF INSURED

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

DECLARATION OF ATTENDING PHYSICIAN

In order for a claim request for a heart attack (myocardial infarction) 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.

By heart attack, we mean a diagnosis, by a cardiologist or internist authorized to practise and practising medicine in a Canadian province, of the death of part of the heart muscle resulting from inadequate blood supply to the appropriate area. The diagnosis must be based on the simultaneous presence of the following two points:

- changes on the electrocardiogram (ECG) indicating a myocardial infarction, and
- an elevated level of cardiac enzymes or any other marker above normal acceptable levels.

1. a) Date of first consultation:

Y	M	D

b) How long has this patient been in your care? _____

2. a) Has a myocardial infarction been diagnosed? Yes No

b) Date of diagnosis :

Y	M	D

c) Who made this diagnosis? _____

d) Please indicate the name and address of any other physician consulted by the patient or the name and address of any hospital where the patient was treated for this hearth attack.

Name of physician or hospital	Address (No., Street, City, Province, Postal Code)	From (year, month, day)	To (year, month, day)																		
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3. Please provide a copy of the tests undergone by the patient in relation to the myocardial infarction.

a) changes to the **ECG** indicating a heart attack or copies of tracings if available.

b) Levels of cardiac enzymes, including CPK – MB and the percentage of total CPK at the time of diagnosis:

CONTINUE OVERLEAF

4. Were other examinations carried out? Please indicate the dates and provide relevant information or reports.

5. When did the patient suffer a heart attack or first show symptoms of having had a heart attack?

Y	M	D

Provide details and describe symptoms.

6. Please describe any predisposing condition or risk factor associated with the patient's heart attack, and include dates.

7. Does the patient have a family history of heart disease, stroke, cancer or diabetes? Please provide details.

8. 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.

9. 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. () _____

SIGNATURE _____ DATE

Y	M	D

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