

Declaration by Insured

**IDENTIFICATION OF INSURED**

Insured – CIS No.  Transit No.  Loan No.

Surname at birth  Date of birth

First name  Sex  M  F Social Insurance Number

**INFORMATION ABOUT CLAIM**

1. Address (No., Street, City, Province)  Postal Code

2. a) Please provide a brief description of the nature and seriousness of your illness.

b) First sign of symptoms.  Y  M  D  
Please describe the symptoms.

c) Date of first consultation with physician for this illness.  Y  M  D  
Please indicate the name and address of the attending physician :  
Name and address :   
Telephone No.: ( )    -

d) Have you undergone tests, examinations, observation or surgical procedures to treat this illness? If so, please indicate the dates and provide details.

e) Have you ever suffered from a similar or related illness, or have you been treated for a similar or related illness?  
 Yes  No  
If so, please indicate the dates and provide details.

**MEDICAL CONSULTATION**

3. a) Please indicate the name and address of the attending physician.  
Name and address :   
Telephone no.: ( )    -

b) Please provide details about any other medical specialist or health professional you have consulted with respect to this illness.

Name	Address (No., Street, City, Province, Postal code)	Telephone No.	Date consulted		
			Y	M	D
( )					
( )					
( )					

**CONTINUE OVERLEAF**

- c) Names and addresses of all physicians or health care professionals (chiropractors, physiotherapists, psychologists, etc.) you consulted, and that treated you during the last five (5) years. Please indicate the reason(s) for each consultation, whether or not they are related to your present condition. If no consultations and/or medical treatments, please indicate this clearly in the space provided below. If more than three(3) consultations, please attached a separate sheet.

Name and address of the physician or health professional	Consultation or treatment dates			Reason of the consultation	Treatment prescribed (medication, chiro, physio, rest, surgery etc.)
	Y	M	D		

- d) What other type of treatment have you received or are you currently receiving for this type of illness (e.g. medications, therapy, etc.)?

#### GENERAL INFORMATION

4. a) Have any of your blood relatives ever suffered from a similar or related illness?  Yes  No

Relationship	Nature of illness	Age when illness was first diagnosed

- b) As one or more members of your biological family (father, mother, brothers or sisters) suffered from diabetes, cancer, a stroke or heart disease before the age of 60 ?  Yes  No

If so, please detailed: \_\_\_\_\_

- c) Do you have insurance coverage with another company for this health condition?  Yes  No

Insurer	Type of coverage	Amount of coverage	Has a claim request been submitted?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

- d) Have you used tobacco in any form whatsoever in the past 12 months?  Yes  No

➤ If so, please indicate the type of product and the quantity consumed each day: \_\_\_\_\_

Indicate the date on which you began using tobacco products. 

Y	M	D

➤ If not, have you ever used tobacco products in the past?  Yes  No

Indicate the date on which you stopped using tobacco products. 

Y	M	D

- e) Please provide any additional information that could support your claim request.

#### SIGNATURE OF INSURED

I Hereby certify that the declarations made in this claim request are complete and accurate.

Signature \_\_\_\_\_

Date 

Y	M	D

To prevent delays in processing your claim, please make sure that all questions have been answered.