

Declaration By Attending Physician

IDENTIFICATION OF INSURED

Insured – CIS No. Transit No. Loan No.

Surname at birth Date of birth

First name Sex M F Social Insurance Number

DECLARATION OF ATTENDING PHYSICIAN

In order for a claim request for a stroke 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 stroke, we mean a diagnosis, by a neurologist or an internist authorized to practise and practising medicine in a Canadian province, of the death of cerebral tissue, caused by a thrombosis, haemorrhage or embolism, from an inter- or extra-cranial region. Measurable and objective signs of neurological incapacity must persist for at least 30 days after the stroke.

1. a) Date of first consultation : Y M D
- b) How long has this patient been in your care? _____
2. a) Has a stroke been diagnosed? Yes No
- b) Date of the stroke. Y M D
- c) Describe the cause of the stroke. _____
- d) Describe any residual neurological effects. _____
- e) How long did the neurological effects last? _____
- f) Who made this diagnosis? _____

Please attach a copy of the computerized axial tomography (CAT) scan or magnetic resonance imaging (MRI), if available.

3. a) When was the patient informed of the diagnosis? Y M D
- b) Who notified the patient? _____
4. a) 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 stroke.

Name of physician or hospital	Address (No., Street, City, Province, Postal Code)	From (year, month, day)	To (year, month, day)
<input type="text"/>	<input type="text"/>	<input type="text"/> Y <input type="text"/> M <input type="text"/> D	<input type="text"/> Y <input type="text"/> M <input type="text"/> D
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- b) List any other examinations or observations and provide details.

CONTINUE OVERLEAF

5. When did the patient have a stroke or first show symptoms of having had a stroke?

Y	M	D

Provide details and describe symptoms.

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

7. Does the patient have a family history of stroke, diabetes, cancer or heart disease before the age of 60 ? 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. ()

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SIGNATURE

DATE

Y	M	D

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