

**Instructions**

Section A must be completed by the insured. Sections B, C, D and E must be completed by the insured's attending physician or the specialist who diagnosed the critical illness.

Critical Illness insurance covers the insured in the event that s/he is diagnosed with one of the critical illnesses listed in his/her contract and according to certain specific criteria or conditions. For this reason, it is very important that we obtain detailed information on the insured's condition so that we may review the claim properly. The purpose of this type of insurance coverage is to help the insured overcome difficulties stemming from the diagnosis of a critical illness.

We are counting on your cooperation to send us the information requested as soon as possible so that we may review this claim. Kindly enclose the additional documents requested with this form.

**i** Fees charged for this statement are to be paid by the insured.

**A. Identification (to be completed by insured)**

<input type="checkbox"/> Individual insurance	Contract no.		
<input type="checkbox"/> GetWell Insurance	Contract no.		
<input type="checkbox"/> Group Insurance	Name of employer	Contract no.	Identification no.
Last name	First name		Date of birth (YYYY-MM-DD)
Address – No., street, apt.		City	Province
			Postal code
10-digit phone number (home)		10-digit phone number (work)	
		Extension	

**B. General information**

Name of physician		Specialty			
Since when have you been following this patient? (YYYY-MM-DD)		Critical illness diagnosis			
When did the symptoms first appear? (YYYY-MM-DD)	Date of first appointment (YYYY-MM-DD)	Date of diagnosis (YYYY-MM-DD)	When was this person first informed of the illness? (YYYY-MM-DD)		
Name and address of hospitals consulted	Name and address of physicians consulted		Date (YYYY-MM-DD)		
Does the patient use tobacco or a tobacco substitute? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient ever used tobacco or a tobacco substitute? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, date stopped (YYYY-MM-DD):</b>					
Do any family members (father, mother, brother, sister, grandfather, grandmother, uncle or aunt) suffer from or have any of them ever suffered from a hereditary illness? <b>If yes, complete the table:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
Family member	Relationship	Illnesses	Age at onset of illness	Age if still living	Age at death

Over the last 5 years, has the patient received care, treatment or services, consulted a physician or been prescribed drugs for this illness or any other condition? If **yes**, complete the table:  Yes  No

Illnesses	Dates (YYYY-MM-DD)	Results	Hospitalization periods	When was the patient informed of the illness? (YYYY-MM-DD)

**C. Details of diagnosis (describe symptoms in section D)**

**Cancer**

**Enclose a copy of the complete medical file, including the pathology report for the biopsy that led to the diagnosis.**

Anatomopathological diagnosis

Cancer site

Cancer stage (I to IV or A to D, as applicable)

Is this a recurrence?

Yes  No

Date of recurrence (YYYY-MM-DD)

**Heart attack / Myocardial infarction**

**Enclose a copy of the complete medical file, including test, bloodwork and ECG results and the hospital discharge summary.**

Any rises and falls of biochemical cardiac markers to levels considered diagnostic of myocardial infarction?

Yes  No

Any new electrocardiogram (ECG) changes consistent with a myocardial infarction?

Yes  No

Is this your patient's first myocardial infarction?

Yes  No

Any new Q waves during or immediately following an intra-arterial cardiac procedure, including an angiography, an angioplasty or other procedure? ?

Yes  No

**Stroke / Cerebrovascular accident**

**Enclose a copy of the complete medical file, including test results and the hospital discharge summary.**

Is this your patient's first cerebrovascular accident ?

Yes  No

Date of cerebrovascular accident (YYYY-MM-DD)

Have any neurological deficits persisted for more than 30 days after the diagnosis ?

Yes  No

**If so**, describe the residual neurological deficits after 30 days.

Was the cerebrovascular accident caused by a trauma ?

Yes  No

**If yes**, describe the trauma.

**Other illness**

**Enclose a copy of the complete medical file, including test results and the hospital discharge summary.**

**D. Description of symptoms, comments and additional details**

Please provide any information you feel would be relevant to our review of your patient's claim for benefits.

---

---

---

---

---

---

---

---

**E. Identification of physician**

Address of physician	Signature of Physician
	Licence no.
Postal code	Date (YYYY-MM-DD)
10-digit phone number	10-digit fax number