Assumption Life

Reset

Physician's Statement – Critical Illness
Neurological Disorders
cerebrovascular accident - coma - bacterial meningitis - paralysis due to an accident or Injury

For policies issued since July 2014

Claimant identification and authorization

First name _____ Last name _____

Policy number _____ Date of birth (DD/MM/YYYY) _____/_____/_____

I hereby authorize the release to Assumption Life of any information with respect to this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

I understand that I am responsible for any charges related to medical reports or the completion of forms.

Claimant's signature _____ Date (DD/MM/YYYY) _____

If the policy owner and the claimant are not the same person, both signatures are required:

Owner's signature _____ Date (DD/MM/YYYY) _____

General information

PLEASE ANSWER ALL QUESTIONS AND INCLUDE REQUESTED SUPPORTING DOCUMENTS.

1. Date of first consultation (DD/MM/YYYY) _____/_____/_____
2. Date of onset of first symptoms (DD/MM/YYYY) _____/_____/_____
3. Description of first symptoms _____
   _____
   _____
4. Names and addresses of other physicians consulted and all hospitals attended by the patient:

Name and Address of Physician or Hospital	Consultation Date / Hospitalization Date*	Medical Problem

***Please include a copy of consultation reports and hospital discharge summaries.**

5. Date patient was advised of his/her diagnosis (DD/MM/YYYY) _____/_____/_____
6. By whom was the diagnosis made? _____
7. Does the patient have any family history of heart disease, stroke, cancer, diabetes or renal problems? ☐ Yes ☐ No
   If yes, provide details: _____
   _____
   _____
8. Details concerning the patient's use of tobacco or nicotine products, including quantity consumed daily as well as the date patient stopped using nicotine/tobacco products _____
   _____

For patient having suffered a cerebrovascular accident

1. Was a diagnosis of cerebrovascular accident (CVA) made? ☐ Yes ☐ No Date diagnosed (DD/MM/YYYY) _____/_____/_____
2. Secondary diagnosis _____ Date diagnosed (DD/MM/YYYY) _____/_____/_____
3. Cause of the CVA and predisposing factors _____
   _____
   _____
4. Description of the residual neurological deficits, and how long the deficits persisted after the diagnosis was made
   _____
   _____

Please provide a copy of the CT scan or MRI reports.

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life
770 Main St. / P.O. Box 160, Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 506-853-5459

For patient having been in a coma

1. Diagnosis _____ Date diagnosed (DD/MM/YYYY) _____/_____/_____
2. Secondary diagnosis _____ Date diagnosed (DD/MM/YYYY) _____/_____/_____
3. Underlying cause(s) which led to the coma _____
   _____
4. Date coma began (DD/MM/YYYY) _____/_____/_____ How long was the patient in a state of coma? _____
5. (a) Tests performed to determine the depth of the coma _____
   _____
   (b) Results of Glasgow Coma Scale while comatose_____
   (c) Was the coma medically induced? ☐ Yes ☐ No
   (d) Was the coma related to alcohol or drug use? ☐ Yes ☐ No
   (e) Was a diagnosis of brain death made? ☐ Yes ☐ No
6. Support systems required to maintain the survival of the patient _____
   _____
7. Are any investigations pending? ☐ Yes ☐ No If yes, provide details: _____
   _____

Please include results of imaging, EEG, and toxicology tests, if applicable.

For patient having suffered from bacterial meningitis

1. Was a diagnosis of bacterial meningitis made? ☐ Yes ☐ No Date diagnosed (DD/MM/YYYY) _____/_____/_____
2. Has the patient ever suffered from bacterial meningitis or any related illness? ☐ Yes ☐ No
   If yes, provide details: _____
3. Description of the residual neurological deficits, and how long the deficits persisted after the diagnosis was made _____
   _____
   _____

Please provide results of cerebral spinal fluid analysis, blood cultures, imaging tests and specialists' consultation reports.

For patient having suffered paralysis as a result of accident or injury

1. Date of accident or injury (DD/MM/YYYY) _____/_____/_____
2. Type of accident _____
3. How soon after the injury or accident did the paralysis begin? _____
4. Which limbs are affected? _____
5. Exact description of loss of function _____
   _____
6. How long has the patient suffered from paralysis?
   _____

Please provide a copy of the results of exploratory tests and of specialists' consultation reports.

Physician's declaration and signature

According to the insurance contract, the term physician means "an individual who holds a valid license from the College of Physicians and Surgeons from the province or territory within which he is practicing in Canada or a valid license in the United States to practice medicine and treat illnesses and injuries, and who practices under the terms of that license. Physician does not include the insured, the owner, or a person who is a member of the insured's or owner's immediate family, nor an individual who holds any other health-related license or degree."

To that effect, we ask the following question: Are you a member of the insured's (claimant's) or policy owner's immediate family? ☐ Yes ☐ No

Physician's Name (in block letters)	Address			
Signature	Date (dd/mm/yyyy)	Telephone	Fax	Specialty

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