

Physician's Statement – Critical Illness Insurance  
Cancer (Life-Threatening) - Aplastic Anemia

**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. Please provide 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 been diagnosed with life-threatening cancer

1. Who advised the patient of his/her diagnosis? \_\_\_\_\_
2. Please indicate:
  - a. Type of cancer \_\_\_\_\_
  - b. Site of cancer \_\_\_\_\_
  - c. Histology and staging \_\_\_\_\_
3. Is there invasion of adjacent tissues or lymph nodes?  Yes  No      Is there presence of distant metastases?  Yes  No  
If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_
4. Has the patient ever suffered from a form of cancer, a malignant tumor, a precancerous condition or other similar problem?  Yes  No  
If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_

**Please include pathology reports.**

For patient having been diagnosed with aplastic anemia

1. Diagnosis \_\_\_\_\_ Date diagnosed (DD/MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Secondary diagnosis \_\_\_\_\_ Date diagnosed (DD/MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Provide details relating to underlying causes, if any \_\_\_\_\_
4. Was the patient transfused with any blood products?  Yes  No  
If yes, provide dates: \_\_\_\_\_  
\_\_\_\_\_
5. Did the patient receive any of the following treatments:
  - a. Bone marrow stimulating agents?  Yes  No  
If yes, provide name of medication and date prescribed: \_\_\_\_\_  
\_\_\_\_\_
  - b. Immunosuppressive agents?  Yes  No  
If yes, provide name of medication and date prescribed: \_\_\_\_\_  
\_\_\_\_\_
  - c. Bone marrow transplant?  Yes  No  
If yes, provide name of transplant centre and date transplant was performed: \_\_\_\_\_  
\_\_\_\_\_
6. Has the patient ever suffered from a form of cancer, a malignant tumor, a precancerous condition or other similar problem?  Yes  No  
If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_

**Please include copies of hematology test results, and bone marrow biopsy results.**

Physician's declaration and signature

According to the terms of the insurance contract, 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 (claimant), the owner, or a person who is a member of the insured (claimant)'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 (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