Assumption Life

Physician's Statement – Critical Illness Insurance
Severe Burns

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

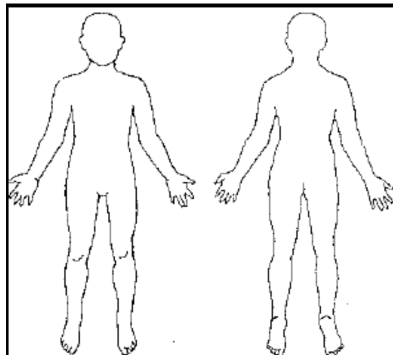
PLEASE ANSWER ALL QUESTIONS AND INCLUDE REQUESTED SUPPORTING DOCUMENTS.

1. Date of first consultation (DD/MM/YYYY) _________/_________/____________
2. Date of incident which led to the burns (DD/MM/YYYY) _________/_________/____________
3. Please describe the circumstances leading to the burns: ____
   ____
   ____

4. Has the patient ever suffered from serious burns? ❑ Yes ❑ No
   If yes, provide details: ____
   ____
   ____

5. Provide a description of the patient's condition, as follows:
   (a) Percentage of body surface covered by the burns ____
   (b) Area of the body affected by the burns (limbs, torso, etc.) ____
   (c)Nature of the burns (first, second and third degree) ____

6. Please shade on the diagram the areas affected by the burns and the degree for each area:



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

7. 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.**

8. Did the patient undergo skin grafts or any other type of surgical intervention or is one planned? ❑ Yes ❑ No
If yes, provide dates and details regarding any surgery performed or planned: ______________________________
____
____

9. Does the patient have any family history of heart disease, stroke, cancer, diabetes or renal problems? ❑ Yes ❑ No
If yes, provide details: ______________________________
____
____

10. 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 ______________________________
____
____

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

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