Assumption Life

Reset

Physician's Statement – Critical Illness Insurance
Blindness - Accidental Loss of Limbs

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 _____
   _____
   _____

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 suffering from blindness

1. What is the corrected vision? Date test was performed (DD/MM/YYYY) _____/_____/_____
   Right eye _____
   Left eye _____
   Both eyes _____

2. What is the field of vision? Date test was performed (DD/MM/YYYY) _____/_____/_____
   Right eye _____
   Left eye _____

3. Cause of blindness _____
   If due to an accident, provide date (DD/MM/YYYY): _____/_____/_____ and circumstances of the accident: _____
   _____
   _____

4. Were there any predisposing conditions or risk factors for developing blindness? ☐ Yes ☐ No
   If yes, provide details: _____
   _____
   _____

5. Is the loss of vision in both eyes total and irreversible? ☐ Yes ☐ No

6. Is there any treatment that could improve this patient's vision? ☐ Yes ☐ No
   If yes, describe the treatment and indicate whether the patient is being or will be assessed for this treatment: _____
   _____
   _____

7. Is there a family history of eye disorders? ☐ Yes ☐ No If yes provide details: _____
   _____
   _____

For patient having suffered an accidental loss of limbs

1. Date of amputation(s) (DD/MM/YYYY) _____/_____/_____
2. Limb(s) amputated _____
3. Exact point of amputation(s)_____
   _____
4. Date of accident (DD/MM/YYYY) _____/_____/_____
5. Circumstances of the accident _____
   _____
   _____

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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