La Capitale

CRITICAL ILLNESS
ATTENDING PHYSICIAN'S STATEMENT

Insured's last name

Insured's first name

Date of birth: Year Month Day

Sex: ☐ F ☐ M

Contract No.

Client No.

THE INSURED IS RESPONSIBLE FOR ANY FEES CHARGED FOR COMPLETING THIS FORM.

INSURED'S AUTHORIZATION

I agree that any information or file concerning my health may be provided to the Insurer. A photocopy of this authorization is considered as valid as the original.

Signed at _____ on this _____ day of _____ 20 _____ .

X _____

Insured's signature or his or her legal guardian's signature, if the insured is under age 18 in Quebec or under age 16 outside Quebec.

ATTENDING PHYSICIAN'S STATEMENT

When disclosing medical and health information, the results of any genetic test should not be included.

1 What is the diagnosis? _____

2 Date of the onset of symptoms: Year Month Day

3 Describe the symptoms: _____

4 Date of the first consultation: Year Month Day

5 Date the insured was informed of the diagnosis or the surgery: Year Month Day

6 Was the insured referred to you by another physician? ☐ Yes ☐ No

If so, the name of the physician: _____

La Capitale Civil Service Insurer Inc. (the Insurer)
625 Jacques-Parizeau St, Quebec QC G1R 2G5

IND217E (03-2020)

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ATTENDING PHYSICIAN'S STATEMENT (cont.)

7 When did the insured become your patient? Year Month Day

8 Names and addresses of other physicians consulted:

Name	Address	Date of consultation
		Year Month Day
		Year Month Day
		Year Month Day

9 Names and addresses of hospitals or institutions the insured visited or to which the insured was admitted:

Name (hospital or institution)	Address	Length of hospitalization:
		From Year Month Day to Year Month Day
		From Year Month Day to Year Month Day
		From Year Month Day to Year Month Day

10 Have any of the insured's family members experienced an identical or similar illness? ☐ Yes ☐ No – **If so:**

Relationship to the insured	Description of the illness	Date and age when first diagnosed
		Year Month Day Age:
		Year Month Day Age:
		Year Month Day Age:

11 Does the insured smoke cigarettes, cigarillos, cigars, a pipe, a bong, a hookah or use betel nut, snuff or marijuana (cannabis) containing any tobacco or nicotine product or use any other form of tobacco or a substitute such as gum, nicotine patch or electronic cigarette? ☐ Yes ☐ No

If so:

Since what date has the insured smoked? Year Month Day

Daily use: _____

If not:

Did the insured previously use tobacco? ☐ Yes ☐ No

If so, what date did the insured quit: Year Month Day

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ATTENDING PHYSICIAN'S STATEMENT (cont.)

12 Additional information: _____

_____

_____

_____

Provide a copy of any available reports or test results related to this diagnosis for assessment by the Insurer's medical director.

13 Are you one of the insured's family members or associates? ☐ Yes ☐ No

Signed at _____ on this _____ day of _____ 20 _____ .

X _____ _____

Attending physician's signature | Attending physician's full name (please print)

☐ General practitioner ☐ Specialist – Specify: _____ Licence No.: _____

_____ _____

Address (No., street, city, province) | Postal code

_____ _____

Area code | Telephone

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