LaCapitale

CRITICAL ILLNESS INSURED'S STATEMENT

Insured's last name

Insured's first name

Date of birth: Year Month Day

Sex: ☐ F ☐ M

Contract No.

Client No.

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

1 What is the nature of the insured's illness?

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 Tests and examinations performed to confirm the diagnosis:

7 Has the insured already experienced this illness or a similar illness? ☐ Yes ☐ No

If so, provide the details and the dates of tests, examinations and treatments:

8 Name and address of the insured's family physician:

Name of physician

Address (No., street, city, province)

Postal code

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625 Jacques-Parizeau St, Quebec QC G1R 2G5

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9 Names and addresses of other physicians consulted:

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

10 Names and addresses of hospitals or institutions where the insured was treated or hospitalized:

Name (hospital or institution)

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

Length of hospitalization: From Year Month Day to Year Month Day

Treatment/surgery:

Name (hospital or institution)

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

Length of hospitalization: From Year Month Day to Year Month Day

Treatment/surgery:

Name (hospital or institution)

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

Length of hospitalization: From Year Month Day to Year Month Day

Treatment/surgery:

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11 Does the insured take medication? ☐ Yes ☐ No – **If so:**

Name of medication	Dosage

12 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:

13 Has the insured or is the insured planning to submit a claim regarding this illness to another insurance company? ☐ Yes ☐ No – **If so:**

Name of the insurance company	Benefit amount	Claim already submitted
	$	☐ Yes ☐ No
	$	☐ Yes ☐ No
	$	☐ Yes ☐ No

14 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:	If not:
Since what date has the insured smoked? Year Month Day	Did the insured previously use tobacco? ☐ Yes ☐ No
Daily use: ______	**If so,** what date did the insured quit: Year Month Day

15 Additional information: ______

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INSURED'S STATEMENT

I acknowledge and agree that the answers given in this form are true and complete.

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

______________________ ______

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

______ ______ ______ ______ ______

Area code Home tel. Area code Work tel. (ext.)

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