La Capitale

CRITICAL ILLNESS – ATTENDING PHYSICIAN'S STATEMENT

☐ Coronary bypass surgery ☐ Myocardial infarction

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 Date of the onset of symptoms: ____ Year ____ Month ____ Day

2 Describe the symptoms: ____________

3 Date of the first consultation: ____ Year ____ Month ____ Day

4 When did the insured become your patient? ____ Year ____ Month ____ Day

5 If the insured had any predisposing conditions or cardiovascular disease risk factors, describe and include dates:

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

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ATTENDING PHYSICIAN'S STATEMENT (cont.)

6 Names and addresses of other physicians consulted:

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

7 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

8 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:

9 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

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ATTENDING PHYSICIAN'S STATEMENT (cont.)

10 Additional information: ______________________________

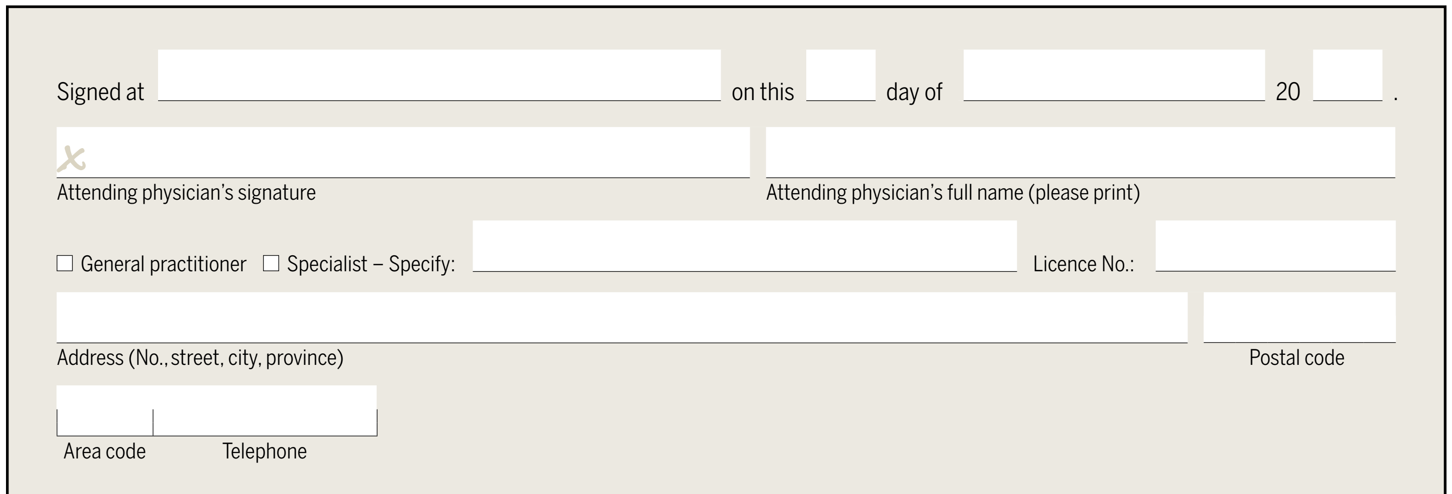
____

____

____

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

11 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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