La Capitale

CRITICAL ILLNESS – ATTENDING PHYSICIAN'S STATEMENT
Coma

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 Cause of the coma: ☐ Accident ☐ Illness ☐ Other: ______

Details: ______

2 Length of coma: ______ days

3 If any of the insured's lifestyle habits or medical history might have increased the risk of coma, describe: ______

4 Names and addresses of other physicians consulted:

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

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

IND221E (03-2020)

CRITICAL ILLNESS – ATTENDING PHYSICIAN'S STATEMENT
Coma

ATTENDING PHYSICIAN'S STATEMENT (cont.)

5 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

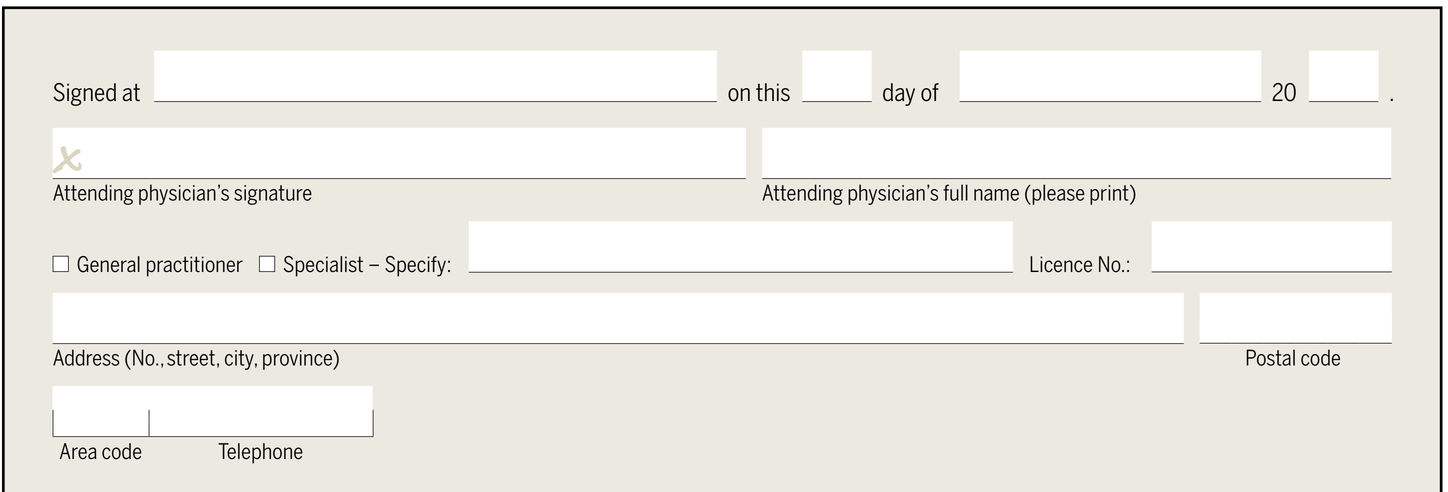
6 Does the insured smoke cigarettes, cigarillos, cigars, a pipe, a bong, a hookah or use betel nut, snuff or marijuana (cannabis) containing any tobacco or nicotine product or use any other form of tobacco or a substitute such as gum, nicotine patch or electronic cigarette? ☐ Yes ☐ No

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

7 Additional information: ____

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

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


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

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

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

IND221E (03-2020)