La Capitale

CRITICAL ILLNESS – ATTENDING PHYSICIAN'S STATEMENT
Kidney failure

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 Cause of the kidney failure: _____

4 Date of the first consultation: Year Month Day

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

6 Does the insured have irreversible end-stage kidney failure affecting both kidneys? ☐ Yes ☐ No

7 Does the insured receive dialysis on a regular basis? ☐ Yes ☐ No – **If so,** since what date? Year Month Day

8 Has the insured had a kidney transplant or has one been recommended? ☐ Yes ☐ No

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

IND223E (03-2020)

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ATTENDING PHYSICIAN'S STATEMENT (cont.)

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

_____

_____

_____

_____

_____

10 Names and addresses of other physicians consulted:

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

11 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

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:

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ATTENDING PHYSICIAN'S STATEMENT (cont.)

13 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

14 Additional information: _____

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

15 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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