beneva

Critical illness

Claimant's statement

Instructions

1. Fill out the claimant's statement and sign the authorizations.
2. Have the back filled out by the attending physician.
3. All costs incurred are at the claimant's expense.

Policy No. _____

Identification of the Claimant

First and last name _____ Name at birth _____

Adresse _____

Province _____ Code postal _____

Sex: ☐ F ☐ M Date of birth (Y Y Y Y M M D D) _____ Home phone _____ Work phone _____

Information Related to the Illness

Does this involve? ☐ a motor vehicle accident ☐ a work accident ☐ a fall ☐ an illness ☐ other: _____

Date of the accident, if applicable, or date of the start of illness: (Y Y Y Y M M D D) _____

Type of injury or illness: _____

Describe the circumstances of the accident, if applicable: _____

If an illness, on what date did the first symptoms appear? (Y Y Y Y M M D D) _____

Date of the first consultation: (Y Y Y Y M M D D) _____

Have you previously suffered from this illness before? ☐ No ☐ Yes If yes, specify the date: (Y Y Y Y M M D D) _____

Name and address of the physician that you consulted the first time for the critical illness

Name and address of the other physicians who have treated you for the critical illness

Name and address of your family physician for the last five (5) years

Have you stayed in a hospital or other health care facility?

☐ No ☐ Yes If yes, which one? _____

Full name and address

Period in hospital: from: (Y Y Y Y M M D D) _____ to: (Y Y Y Y M M D D) _____

Do you use tobacco products (cigarette, cigar, pipe, cigarillos) or in any other form? ☐ No ☐ Yes

Have you ever used tobacco products? ☐ No ☐ Yes If yes, on what date did you stop smoking? (Y Y Y Y M M D D) _____

Are declare that the above answers are complete and truthful.
All costs incurred in filling out this form are at the claimant's expense.

X _____ (Y Y Y Y M M D D) _____

Claimant's signature Date

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Critical illness
Claimant's statement

Instructions
1. Fill out the attending physician's statement and return it to the patient.
2. Provide a full copy of your medical records with respect to the critical illness, from the firts symptoms to the diagnosis date, including the clinical notes, exams/tests, pathology report (for cancer).
3. All costs incurred are at the patient's expense.

Patient's Last and first name

Diagnosis

Main diagnosis: _____ Date of this diagnosis: Y Y Y Y M M D D

Is the patient's current state:

☐ Due to an illness If yes, specify the illness: _____

☐ Due to an accident If yes, specify the type of accident: ☐ work ☐ motor vehicle ☐ other: _____

☐ Work-related If yes, explain: _____

Considering your patient's current condition, is this a first ever diagnosis of cancer?

☐ No ☐ Yes If yes, specify: _____

If this is not a first ever diagnosis of cancer, specify: Date of the previous diagnosis (Y Y Y Y M M D D) Previous type of cancer

Was the patient in hospital? ☐ No ☐ Yes Date of admission to hospital (Y Y Y Y M M D D) Date of discharge (Y Y Y Y M M D D)

If yes, specify: _____

Name of hospital centre City

What are the objective symptoms? **(Attach copies of results from recent X-ray, electrocardiogram and other tests and examinations)**

When did the symptoms appear for the first time, or when did the accident occur? Y Y Y Y M M D D

Date of the first medical visit Y Y Y Y M M D D

Did the patient suffer previously from this condition or a similar condition? ☐ No ☐ Yes

Y Y Y Y M M D D Y Y Y Y M M D D Y Y Y Y M M D D

If yes, specify the date(s) of the previous episode(s)

Has the patient previously, for the primary diagnosis, received medical treatment, consulted a physician, undergone examinations, made use of medication or been hospitalized? ☐ No ☐ Yes If yes, please specify: _____

Has the patient remained under your care since the onset of the illness or since the accident? ☐ No ☐ Yes

On what date was the patient referred to you? Y Y Y Y M M D D

If the patient was referred to you by other physicians, indicate their names, addresses and phone numbers: _____

Does the patient use tobacco products (cigarette, cigar, pipe, cigarillos) or in any other form? ☐ No ☐ Yes

Has the patient ever used tobacco products? ☐ No ☐ Yes If yes, when did the patient stop? Y Y Y Y M M D D

Additional information: _____

Attending physician's full name (please print) Licence No.

Are you related to the patient? ☐ No ☐ Yes If yes, please specify: _____

Attending physician's address Telephone

X _____ Y Y Y Y M M D D

Attending physician's signature Date