canada life™

Physician's initial statement

Critical illness claim

1. Patient information

1.1 Policy numbers: ______________________

1.2 Name of insured: ______________________

1.3 Date of birth (day/month/year): ______________________

1.4 Address (street number and name): ______________________

City: ______________________ Province: ____________ Postal code: ____________

1.5 Phone number: ______________________

2. Medical condition

2.1 Indicate the diagnosis: ______________________

2.2 Date of diagnosis (day/month/year): ______________________

Evidence required

In order to consider this claim, please provide copies of all medical evidence regarding the investigation, diagnosis and treatment of this condition including test results, laboratory results, surgical reports and consultation reports.

Example:

- Cancer: provide initial consultation report, pathology report and oncology report.
- Heart attack: provide all ECG reports, laboratory results, angiography or cath lab reports and clinical chart notes.

3. History of condition

3.1 How long has this person been your patient? ______________________

3.2 Was your patient referred to you?

☐ Yes, provide the name of the referring physician: ______________________

☐ No

3.3 On what date did your patient first have symptoms? (day/month/year) ______________________

3.4 On what date did your patient first consult you for this condition? (day/month/year) ______________________

3.5 Has your patient previously suffered from the condition specified above or any related condition?

☐ Yes, provide dates and details: ______________________

☐ No

3.6 Relevant family history:

____

3.7 Smoking history:

____

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4. Treatment

4.1 Provide the names and addresses of other physicians consulted or hospitals attended by your patient for this condition.

Name of physician or hospital: ______________________________
Address (street number and name, city, province, postal code): ______________________________
From (day/month/year): ______________ To (day/month/year): ______________

Name of physician or hospital: ______________________________
Address (street number and name, city, province, postal code): ______________________________
From (day/month/year): ______________ To (day/month/year): ______________

Name of physician or hospital: ______________________________
Address (street number and name, city, province, postal code): ______________________________
From (day/month/year): ______________ To (day/month/year): ______________

4.2 Provide any other information that would be helpful in the assessment of your patient's claim.

5. Physician information and signature

5.1 Name of physician: ______________________________

5.2 Specialty: ______________________________

5.3 Phone number: ______________ Fax number: ______________

5.4 Address (street number and name): ______________________________

City: ______________ Province: ______________ Postal code: ______________

Date signed (day/month/year): ______________________________

X ______________________________
Signature of **physician**

- The patient is responsible for any fees related to the completion of this form and any other medical information provided.
- Mail, email or fax to:

  The Canada Life Assurance Company
  Living Benefits Claims
  PO Box 6000, Winnipeg MB R3C 3A5

  Email: lbclaims@canadalife.com
  Fax: 1-204-946-4030