canada life™

# Physician's initial statement

## Child critical illness claim

## 1. Patient information

**1.1** Policy numbers: _____

**1.2** Name of insured child: _____

**1.3** Date of birth (day/month/year): _____

**1.4** Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

**1.5** Phone number: _____

### Authorization

I hereby authorize the release to The Canada Life Assurance Company of any information or records of the insured child's health for the purpose of administering a claim under the above noted policy. This authorization shall continue in effect for a period of one year from the date of execution.

Date signed (day/month/year): _____

X _____

Signature of **insured child**, if over 18 years

X _____

Signature of **parent or guardian**, if the insured child is under 18 years

## 2. Physician's report

**2.1** Indicate the diagnosis: _____

**2.2** On what date did your patient first have symptoms? (day/month/year) _____

Describe the symptoms: _____

**2.3** On what date did the patient first consult you for this condition? (day/month/year) _____

**2.4** Was your patient referred to you?

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

☐ No

**2.5** 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): _____

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

**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.

## 3. Physician information and signature

**3.1** Name of physician: _____

**3.2** Specialty: _____

**3.3** Phone number: _____ Fax number: _____

**3.4** Address (street number and name): _____

City: _____ Province: _____ Postal code: _____

Date signed (day/month/year): _____

X _____

Signature of **physician**

- The patient, parent or guardian 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