Assumption Life
Group Insurance

CRITICAL ILLNESS CLAIM FORM

Assumption Life
Group Insurance

Critical Illness Claim Form Instructions

Policyholder (employer or plan administrator)

Please complete the "Policyholder's Statement" and ensure that you answer each question to avoid file review delays.

Employee

1. Please complete the "Employee's Statement" and ensure that you answer each question to avoid file review delays. Do not forget to sign the "Employee's Authorization & Acknowledgement" in section 2.

2. Please ensure that your attending physician completes the medical declaration. You must also complete the "Employee Identification" section AND sign the authorization at the top of the "Attending Physician's Declaration".

Please note:

a) It is your responsibility to pay any fees that may be incurred to have this form completed by your attending physician.

b) Please return the entire document to the following address and include all pages. **Please do not use staples.**

ASSUMPTION LIFE, c/o Group Insurance
P.O. Box 160 / 770 Main Street
Moncton NB E1C 8L1
Telephone: 506-869-9797 or 1-888 869-9797 Fax: 506-853-5434

c) Alternatively, you can **scan** and **e-mail** the forms to: lifedisability@assumption.ca

Attending Physician

1. Please complete the medical declaration ensuring that you answer each question to avoid file review delays.

2. Please attach to the form any other documentation pertinent to the evaluation of this claim (test results of various examinations carried out and specialist consultation reports).

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P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-888-869-9797 Fax 506-853-5434 E-mail : lifedisability@assumption.ca

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Critical Illness Claim Form Policyholder's Statement

To speed processing, please answer all questions. Please Print.

Name of Policyholder _____ Telephone _____ E-mail _____

Address _____ City _____ Province _____ Postal Code _____

Section 1 Employee Information

Employee's First Name _____ Employee's Last Name _____ Policy _____ Division _____ Certificate _____

1. Occupation: _____
2. Date hired: (DD/MM/YYYY) ___ / ___ / _____
3. Certificate effective date: (DD/MM/YYYY) ___ / ___ / _____
4. Last day at work: (DD/MM/YYYY) ___ / ___ / _____
5. Amount of coverage $ _____
6. Please add any other comments relevant to this claim. _____

I certify the accuracy of the above information.

First name and last name of the authorized person (in block letters) _____ Position _____

Signature _____ Date (DD/MM/YYYY) _____

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Critical Illness Claim Form Employee's Statement

To speed processing, please answer all questions and obtain all required signatures.

First Name _____ Last Name _____ Policy _____ Division _____ Certificate _____

Email _____ Date of birth (DD/MM/YYYY) ___ / ___ / _____ Gender: ☐ F ☐ M

Address _____ City _____ Province _____ Postal Code _____

Telephone - Home _____ Telephone – Work _____ Telephone - Cell _____

Date of onset of illness: (DD/MM/YYYY) ___ / ___ / _____ Date of surgery (if applicable): (DD/MM/YYYY) ___ / ___ / _____

Section 1 Claim and Related Details

1. Please indicate the type of critical illness for which you are submitting a claim. _____

2. Please give full details of the extent and nature of your illness. _____

3. Have you previously suffered from, or received treatment for, the same or a similar or related illness? ☐ Yes ☐ No
   If yes, please give full details. _____

4. On what date did you first consult a doctor regarding your illness? _____

5. When were you first informed of your illness? (DD/MM/YYYY) ___ / ___ / _____

6. Please give details of the treatment you received including details and date of any hospital investigations or in-patient treatment. _____

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Name of employee: _____

Section 1 Claim and Related Details (continued)

7. Have you consulted a physician or a health care professional or been hospitalized for one or more medical reasons during the two (2) years preceding the current illness? ☐ Yes ☐ No If yes, complete the following table:

Name of Treating Physicians or Health Care Professionals	Type of Illness or Injury	Dates of Consultations (DD/MM/YYYY)	Name and Location of Hospitals Where Treatment Occurred	Hospitalization Periods (DD/MM/YYYY)
				___/___/_____ to ___/___/_____
				___/___/_____ to ___/___/_____
				___/___/_____ to ___/___/_____
				___/___/_____ to ___/___/_____
				___/___/_____ to ___/___/_____
				___/___/_____ to ___/___/_____
				___/___/_____ to ___/___/_____

8. Were any prescribed medications taken during the two (2) years prior to the current illness? ☐ Yes ☐ No
If yes, complete the following table:

Illness	Name of Medication	Periods (DD/MM/YYYY)
		___/___/_____ to ___/___/_____
		___/___/_____ to ___/___/_____
		___/___/_____ to ___/___/_____
		___/___/_____ to ___/___/_____
		___/___/_____ to ___/___/_____
		___/___/_____ to ___/___/_____
		___/___/_____ to ___/___/_____

9. Is there a history of this disease or a similar disease among your family members (father, mother, sister, brother, grandfather, grandmother, uncle, aunt)? ☐ Yes ☐ No If yes, complete the following table:

Name of Family Member	Relationship	Illnesses	Age at Onset of Illness	Age if Still Living	Age at Death (if applicable)

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Name of employee: _____

Section 1 Claim and Related Details (continued)

10. Please provide names, complete addresses, telephone numbers of all physicians who have treated you for this illness and the consultation dates.

Name of Physician	Complete Address	Telephone	Dates (DD/MM/YYYY)

11. Please provide name, complete address and phone number of your family physician.

Name of physician	Complete Address	Telephone

Section 2 Employee s Authorization & Acknowledgement

I hereby confirm that the information contained in this claim form for a critical illness benefit is true and complete to the best of my knowledge.

I consent to the release of the information contained in this claim form to Assumption Life, its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and processing of the claim.

I authorize any healthcare provider or professional, medical organization, insurance or reinsurance company, worker's compensation board, the policyholder, my employer, as well as any other person, public or private organization or institution to disclose to Assumption Life, its employees, agents and service providers any information which they may need in the assessment of the claim.

I understand and acknowledge that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, Assumption Life will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or any professional organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating such fraud or abuse.

I agree that a photocopy of this Authorization & Acknowledgement shall be as valid as the original.

_____ _____

Employee's signature Date (DD/MM/YYYY)

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Section 1 To Be Completed by the Employee

First Name	Last Name	Policy	Division	Certificate

___ / ___ / _____
Date of birth (DD/MM/YYYY)

Telephone - Home

Telephone - Cell

I hereby authorize any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physician's notes) or knowledge concerning myself with Assumption Mutual Life , its employees, reinsurers or agency acting on behalf of Assumption Mutual Life which is necessary for the purpose of assessing my critical illness claim. A photocopy of this authorization shall be as valid as the original. This authorization is valid only for this critical illness claim.

Employee's Signature

Date (DD/MM/YYYY)

Section 2 To Be Completed by the Attending Physician

Section 2 must be completed by the employee's attending physician or the specialist who diagnosed the critical illness.

Critical illness insurance covers the employee in the event that he/she is diagnosed with one of the critical illnesses listed in his/her insurance policy and according to certain specific criteria or conditions. For this reason, it is very important that we obtain detailed information on the employee's condition so that we may review the claim properly. The purpose of this type of insurance coverage is to help the employee overcome difficulties stemming from the diagnosis of a critical illness.

We are counting on your cooperation in sending us the requested information as soon as possible, so as to avoid any delays in the evaluation of this claim. Kindly enclose the additional requested documents with this form.

PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE EVALUATION OF THIS CLAIM.

1. Diagnosis

A) Date of critical illness diagnosis: (DD/MM/YYYY) ___ / ___ / _____

B) Primary Diagnosis:_____

C) Secondary Diagnosis: _____

D) For illnesses or associated symptoms diagnosed, has the patient previously:

☐received medical treatments ☐consulted another physician ☐been hospitalized ☐taken medication ☐undergone examinations

Specify the periods: _____

_____

2. Treatment

A) Medications:

Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____

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Name of employee: _____

Section 2 To be Completed by the Attending Physician (continued)

2. Treatment (continued)

B) Has the patient undergone or will her/she undergo:

Examination or tests ☐ Yes ☐ No Specify: _____

Surgery ☐ Yes ☐ No ☐ Day Procedure Date: (DD/MM/YYYY) ___ / ___ / _____ Type: _____

Other treatments ☐ Yes ☐ No Type:_____ Name of practitioner: _____
Commencement date: (DD/MM/YYYY) ___ / ___ / _____

C) Hospitalization: from (DD/MM/YYYY) ___ / ___ / _____ to ___ / ___ / _____
A short stay under observation ☐ Yes ☐ No Number of hours: _____ Date: (DD/MM/YYYY) ___ / ___ / _____
Name of hospital: _____ Location: _____

3. General Information

A) Since when have you been following this patient? (DD/MM/YYYY) ___ / ___ / _____

B) Date of first appointment: (DD/MM/YYYY) ___ / ___ / _____

C) When did the symptoms first appear? (DD/MM/YYYY) ___ / ___ / _____
When was the patient informed of the diagnosis? (DD/MM/YYYY) ___ / ___ / _____

D) Has the patient been followed by other physicians? ☐ Yes ☐ No
If yes, complete the following table:

Name of Physicians Consulted	Complete Address	Date (DD/MM/YYYY)
		___ / ___ / _____
		___ / ___ / _____
		___ / ___ / _____
		___ / ___ / _____
		___ / ___ / _____

E) Do any family members (father, mother, brother, sister, grandfather, grandmother, uncle or aunt) suffer from or have any of them ever suffered from the same or a similar illness? ☐ Yes ☐ No If yes, complete the following table:

Name of Family Member	Relationship	Illnesses	Age at Onset of Illness	Age if Still Living	Age at Death (if applicable)

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Name of employee: _____

Section 2 To be Completed by the Attending Physician (continued)

3. General Information (continued)

F) Over the last five (5) years, has the patient received care, treatment or services, consulted a physician or been prescribed drugs for this illness or any other condition? ☐ Yes ☐ No If yes, complete the following table:

Name of Treating Physicians or Health care Professionals	Type of Illness or Injury	Dates of Consultations (DD/MM/YYYY)	Name and Location of Hospitals Where Treatment Occurred	Hospitalization Periods (DD/MM/YYYY)
				___ / ___ / _____ to ___ / ___ / _____
				___ / ___ / _____ to ___ / ___ / _____
				___ / ___ / _____ to ___ / ___ / _____
				___ / ___ / _____ to ___ / ___ / _____
				___ / ___ / _____ to ___ / ___ / _____

4. Details of Diagnosis

☐ **Cancer**

Enclose a copy of the complete medical file, including the pathology report for the biopsy that led to the diagnosis.

A) Anatomopathological diagnosis: _____

B) Cancer site: _____

C) Cancer Stage (I to IV or A to D, as applicable): _____

D) Is this a recurrence? ☐ Yes ☐ No Date of recurrence: (DD/MM/YYYY) ___ / ___ / _____

☐ **Heart Attack / Myocardial Infarction**

Enclose a copy of the complete medical file, including diagnostic testing results, as well as hospital discharge summaries.

A) Any rise and falls of biochemical cardiac markers to levels considered diagnostic of myocardial infarction? ☐ Yes ☐ No

B) Any new electrocardiogram (ECG) changes consistent with a myocardial infarction? ☐ Yes ☐ No

C) Is this your patient's first myocardial infarction? ☐ Yes ☐ No

D) Any new Q waves during or immediately following an intra-arterial cardiac procedure, including an angiography, an angioplasty or other procedure? ☐ Yes ☐ No

☐ **Stroke / Cerebrovascular Accident**

Enclose a copy of the complete medical file, including diagnostic testing results, as well as hospital discharge summaries.

A) Is this your patient's first cerebrovascular accident? ☐ Yes ☐ No Date of cerebrovascular accident: (DD/MM/YYYY) ___ / ___ / _____

B) Have any neurological deficits persisted for more than 30 days after the diagnosis? ☐ Yes ☐ No
If yes, describe the neurological deficits after 30 days. _____
_____
_____

C) Was the cerebrovascular accident caused by trauma? ☐ Yes ☐ No
If yes, describe the trauma. _____
_____
_____

☐ **Other illness**

Enclose a copy of the complete medical file, including diagnostic testing results, as well as hospital discharge summaries.

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Name of employee: _____

Section 2 To Be Completed by the Attending Physician (continued)

5. Description of Symptoms, Comments and Additional Details

Please provide any information you feel would be relevant to our review of your patient's claim for benefits. _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

6. Identification of the Attending Physician

First Name _____ Last Name _____

Full address _____

Telephone _____ Fax _____

☐ General practitioner ☐ Specialist (specify) _____ ☐ Other (specify) _____

_____ _____

Signature of Attending Physician Date (DD/MM/YYYY)

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY FEES INCURRED TO COMPLETE THIS FORM.

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