

**Physician's Statement – Critical Illness Insurance  
Cardiovascular Disorders**

myocardial infarction (heart attack) – coronary artery bypass - aortic surgery – heart valve replacement or repair

**For policies issued since July 2014**

**Claimant identification and authorization**

First name \_\_\_\_\_ Last name \_\_\_\_\_

Policy number \_\_\_\_\_ Date of birth (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

I hereby authorize the release to Assumption Life of any information with respect to this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

I understand that I am responsible for any charges related to medical reports or the completion of forms.

Claimant's signature \_\_\_\_\_ Date (DD/MM/YYYY) \_\_\_\_\_

If the policy owner and the claimant are not the same person, both signatures are required:

Owner's signature \_\_\_\_\_ Date (DD/MM/YYYY) \_\_\_\_\_

**General information**

**PLEASE ANSWER ALL QUESTIONS AND INCLUDE REQUESTED SUPPORTING DOCUMENTS.**

1. Date of first consultation (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
2. Date of onset of first symptoms (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
3. Description of first symptoms \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Names and addresses of other physicians consulted and all hospitals attended by the patient:

Name and Address of Physician or Hospital	Consultation Date / Hospitalization Date*	Medical Problem

**\*Please include a copy of consultation reports and hospital discharge summaries.**

5. Date patient was advised of his/her diagnosis (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
6. By whom was the diagnosis made? \_\_\_\_\_
7. Does the patient have any family history of heart disease, stroke, cancer, diabetes or renal problems?  Yes  No  
If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_
8. Details concerning the patient's use of tobacco or nicotine products, including quantity consumed daily as well as the date patient stopped using nicotine/tobacco products \_\_\_\_\_  
\_\_\_\_\_

For patient having suffered a myocardial infarction

1. Has a myocardial infarction been diagnosed?  Yes  No Date diagnosed (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
2. Secondary diagnosis \_\_\_\_\_ Date diagnosed (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
3. Provide details relating to underlying causes, if any: \_\_\_\_\_
4. Details regarding the results of biochemical cardiac markers (type and levels) \_\_\_\_\_  
\_\_\_\_\_
5. Were changes noted on the ECG indicating a heart attack?  Yes  No

Please include copies of ECG tracings, results of biochemical cardiac markers, and other medical investigations done in relation to this diagnosis.

For patient having had coronary artery bypass surgery, aortic surgery, heart valve replacement or repair

1. Diagnosis \_\_\_\_\_ Date diagnosed (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
2. Secondary diagnosis \_\_\_\_\_ Date diagnosed (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
3. Provide details relating to any underlying causes: \_\_\_\_\_  
\_\_\_\_\_
4. Surgeon's name \_\_\_\_\_
5. Date of surgery (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
6. Name and address of hospital where surgery was performed \_\_\_\_\_
7. Type of surgery performed and details (number and placement of grafts, which heart valve was involved, etc.) \_\_\_\_\_  
\_\_\_\_\_

Please include the surgical report.

Physician's declaration and signature

According to the insurance contract, the term physician means "an individual who holds a valid license from the College of Physicians and Surgeons from the province or territory within which he is practicing in Canada or a valid license in the United States to practice medicine and treat illnesses and injuries, and who practices under the terms of that license. Physician does not include the insured, the owner, or a person who is a member of the insured's or owner's immediate family, nor an individual who holds any other health-related license or degree".

To that effect, we ask the following question: Are you a member of the insured's (claimant's) or policy owner's immediate family?  Yes  No

\_\_\_\_\_  
Physician's Name (in block letters) Address

\_\_\_\_\_  
Signature Date (dd/mm/yyyy) Telephone Fax Specialty