CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—HEART VALVE REPLACEMENT

Original signatures must be submitted to Empire Life.

To be completed by Patient.

Name of Patient (please print)	First Name	Initial	Last Name	
Date of birth (dd/mmm/yy)		Policy number		
Present Address	Street	City	Province	Postal Code
I hereby authorize the release to my insurer, The Empire Life Insurance Company, or their reinsurer, any information requested in respect of this claim.				
Patient's Signature				Date (dd/mmm/yy)
The patient is responsible for charges incurred for the completion of this form.				

To be completed by Physician who is attending the Patient.

1. a) What is the diagnosis?

b) What treatment occurred because of this diagnosis?

2. a) On what date did your patient first have symptoms? (dd/mmm/yy)

b) Please describe them.

3. a) When did your patient first consult you for this condition? (dd/mmm/yy)

b) Has your patient previously suffered from a myocardial infarction or any predisposing disorders?

4. How long has the insured been your patient?

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5. a) On what date was the patient first advised of the need for heart valve replacement? (dd/mmm/yy) By whom?

b) Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related condition.

6. a) Please provide the date the heart valve replacement was performed. (dd/mmm/yy)

b) Please provide a copy of the surgical report and details of valve involved.

7. Is there a family history of heart disease? Please provide details.

8. Is there any other significant family medical history?

9. Please provide details of your patient's tobacco use including amount per day and date last used.

10. Please provide any other information that would be helpful in the assessment of your patient's claim.

11. Our contract requires that a covered illness be diagnosed by a physician who is not related to or in a business relationship with the insured. Are you related to or in a business relationship with this patient? Yes ◯ No ◯

Please provide copies of all specialist or hospital reports including the initial consult report for our Medical Consultant's review.

Physician's Signature	Date (dd/mmm/yy)	
Address Street City Province Postal Code		
Name (in block capitals)	Telephone	Fax