

# CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—AORTA SURGERY

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)
<b>The patient is responsible for charges incurred for the completion of this form.</b>			

## To be completed by Physician who is attending the Patient.

1.	What is the diagnosis?
2.	a) On what date did your patient first have symptoms? (dd/mmm/yy) b) Please describe them.
3.	When did your patient first consult you for this condition? (dd/mmm/yy)
4.	How long has the insured been your patient?
5.	a) Please provide the date the aorta surgery was performed. (dd/mmm/yy) b) Please provide a copy of the surgical report and details of aorta involved.

6. On what date was the patient first advised of the diagnosis? (dd/mmm/yy) By whom?

7. Please provide:

a) A copy of any tests confirming the diagnosis.

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

c) Name and address of the surgeon/physician who confirmed the diagnosis.

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

9. Is there any other significant family medical history?

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

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

12. 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