CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—BENIGN BRAIN TUMOR

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.	What is the diagnosis?
2.	a) On what date did your patient first have symptoms? (dd/mmm/yy)
	b) What were they?
	c) On what date did your patient first consult you for this condition? (dd/mmm/yy)
	d) How long has this person been your patient?
3.	Are there permanent neurological deficits? If so, please outline the clinical course and briefly describe the patient's neurological signs and symptoms, giving dates and duration of episodes.
4.	a) On what date was the diagnosis of possible Brain Tumor first discussed with the patient? (dd/mmm/yy)
	b) On what date was the diagnosis confirmed? (dd/mmm/yy)

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5. a) Please provide copies of all neuroimaging or pathology reports that support this diagnosis.

b) Please provide the name and address of the neurologist who confirmed the diagnosis.

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

7. a) Is there family history of tumours? Please provide details.

b) Is there any other significant family history.

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

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

10. 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