# CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—HEART ATTACK (MYOCARDIAL INFARCTION)

Original signatures must be submitted to Empire Life.

**To be completed by Patient.**

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|---|---|---|---|---|
| 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) Was a diagnosis of myocardial infarction made? Yes ◯ No ◯

b) On what date was the diagnosis made? (dd/mmm/yy)

c) By whom was the diagnosis made?

d) Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this heart attack. (Please use additional paper and attach, if necessary.)

**2.** a) On what date did your patient first consult you for this condition? (dd/mmm/yy)

b) How long has this person been your patient?

**3.** Please provide the following details pertaining to the insured's myocardial infarction:
a) Description and date of onset of chest pain.



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b) ECG changes in detail at time of event or provide copies of tracings, if available.

c) Cardiac enzyme levels, including CPK-MB fraction and percentage of total CPK at time of diagnosis.

**4.** What other investigations have been performed? Please provide dates, details and reports.

**5.** When did your patient first suffer symptoms or episodes of cardiovascular disease? Please provide details and dates.

**6.** Please describe including dates, any predisposing conditions or risk factors which your patient has had for cardiovascular disease.

**7.** a) Is there a family history of cardiovascular disease or cerebrovascular disease? Please provide details.

b) Please provide details of any other significant family history.

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

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

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| **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<br>Street City Province Postal Code | | |
| Name (in block capitals) | Telephone | Fax |