CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—CANCER

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

d) How long has the insured been your patient?

3. a) Please provide the date this cancer was diagnosed. (dd/mmm/yy)

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

4. Please provide a copy of the pathology report giving the following details:

- Type of tumour
- Site of tumour
- Histology and Staging

5. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer.

Empire Life

6. a) Has your patient previously suffered from cancer or any predisposing disorders? Is so, please provide dates and details.

b) Has your patient ever been tested for the Human Immunodefiency Virus?

Date (dd/mmm/yy) Result

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

b) Please provide details of 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