CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—STROKE/CEREBROVASCULAR ACCIDENT (CVA)

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) Was a diagnosis of stroke or cerebrovascular accident made? Yes ◯ No ◯

b) On what date did the stroke/CVA occur? (dd/mmm/yy)

c) By whom was the diagnosis made?

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

e) Who advised the patient of the diagnosis?

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

2. When did your patient first suffer symptoms or episodes of cerebrovascular disease? Please provide details and dates.

3.

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?

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4. Please describe the cause of the stroke/CVA.

5. a) Please describe the measurable residual neurological deficits.

b) How long have the measurable residual neurological deficits persisted and is further improvement likely?

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

7. Please describe including dates, any predisposing conditions or risk factors which your patient has had for cerebrovascular disease.

8. 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.

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