CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—MULTIPLE SCLEROSIS

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) What was the date of onset of the Multiple Sclerosis symptoms? (dd/mmm/yy)
	b) Please describe them.
2.	When did the patient first consult you for this condition? (dd/mmm/yy)
3.	How long has the insured been your patient?
4.	Describe the progression of the disease including the neurological signs and symptoms presented by the patient and include the dates and the duration of the symptoms.
5.	On what date was the patient first advised of a possible diagnosis of Multiple Sclerosis? (dd/mmm/yy)
6.	Please provide: a) A copy of any scans or other tests confirming the diagnosis.
	b) The names and addresses of other doctors consulted or hospitals that the patient was admitted to for this disease.
	c) Name and address of the neurologist who confirmed the diagnosis.

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7.	Is there a family history of Multiple Sclerosis? Please provide details.

8.	Is there any other significant family medical 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