CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—RENAL FAILURE

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 is the diagnosis?

b) Are both kidneys affected? If yes, is the failure irreversible?

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

b) How long has the insured been your patient?

c) Please provide the date renal failure was diagnosed? (dd/mmm/yy)

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

3. Please provide:
a) Details of relevant investigations and laboratory results.

b) The names and addresses of other physicians consulted or hospitals attended by your patient for this or any related condition.

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4. Please describe, including dates, any predisposing disorders or risk factors that your patient had for renal disease including but not limited to diabetes and hypertension.

5. a) Is there a family history of kidney disorders?

b) Is there any other significant family medical history?

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

7. Please provide any other information including current treatment that would be helpful in the assessment of your patient's claim.

8. 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