CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—LOSS OF LIMBS

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) What was the cause of the loss?

c) When did you first see the patient for this condition? (dd/mmm/yy)

d) How long has the insured been your patient?

2. a) Is the loss complete and permanent? Please provide details.

b) Has the loss continued for a period of 180 days?

3. On what date was the patient first advised of a diagnosis? (dd/mmm/yy) By whom?

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4. Please provide:
a) A copy of any tests, consultations or hospital reports regarding the condition.

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

c) Name and address of the physician who confirmed the diagnosis.

5. Has your patient previously suffered from any predisposing disorders? If so, please provide dates and details.

6. Is there any other significant family medical history?

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

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

9. 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