CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—OCCUPATIONAL HIV INFECTION

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

c) How long has the insured been your patient?

2. a) On what date did your patient first become infected with the HIV virus? (dd/mmm/yy)

b) Please provide full details including copies of any reports regarding the initial injury causing the infection.

3. a) When was the first HIV test taken after the initial injury? Please provide date and results. (dd/mmm/yy)

b) Please provide the date and results of any additional HIV tests. (dd/mmm/yy)

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

5. Please provide:
a) A copy of all tests confirming the diagnosis of HIV.

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.

6. a) Please provide details of anything in the patient's habits, personal medical history or family medical history which would have increased the risk or contributed to his/her condition.

b) Has your patient ever been tested for HIV prior to this diagnosis?

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

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