CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—LOSS OF INDEPENDENCE AND/OR COGNITIVE IMPAIRMENT

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) On what date did your patient first have symptoms? (dd/mmm/yy) Please provide details.

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

d) How long has the insured been your patient?

2. a) Please provide the date your patient was diagnosed as being unable to perform activities of daily living. (dd/mmm/yy)

b) What activities of daily living were they unable to perform?

c) What activities of daily living are they currently unable to perform?

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

4. Please provide:

a) A copy of the standard measurements and results used to make a diagnosis of loss of independence and/or cognitive impairment.

b) The names and addresses of other physicians or practitioners 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