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

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.	What is the diagnosis?
2.	On what date did your patient first have symptoms or become aware of the loss of speech? (dd/mmm/yy) Please provide details.
3.	When did the patient first consult you for this condition? (dd/mmm/yy)
4.	How long has the insured been your patient?
5.	a) Please provide the date loss of speech was diagnosed as permanent and irreversible. (dd/mmm/yy)
	b) Please describe the degree of loss of speech.

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

Please provide:
a) A copy of any tests confirming the diagnosis of permanent loss of speech.

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.

7. Is there a family history of speech problems? 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