CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—TRANSPLANT OF A VITAL ORGAN

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) Please provide complete details of the disorder leading to your patient's transplant procedure.

b) On what date did your patient first suffer symptoms of this disorder? (dd/mmm/yy) What were they?

c) On what date was the disorder first diagnosed? (dd/mmm/yy)

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

2. How long has end stage disease been present?

3. Please provide details of the transplant procedure to be performed, including the name and address of the hospital, the attending surgeon/physician and the date of the procedure.

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4. Please describe including dates, any predisposing disorders or risk factors your patient had for the underlying disorder.

5. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related condition.

6. a) Is there anything in your patient's habits or family history that increased the risk for the underlying disorder? If so, please provide details.

b) Please provide details of any other significant family 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

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