CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—CORONARY ARTERY BYPASS SURGERY

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. On what date did your patient first have any symptoms? (dd/mmm/yy) What were they?

2. When was coronary angiography undertaken? Please include a copy of the results, if available.

3. Provide the date of coronary artery bypass surgery and which arteries were bypassed. Please include a copy of the operative report, if available.

4. Please indicate those risk factors for Coronary Artery Disease present in your patient. Please provide details.

○ Tobacco Use ○ Diabetes ○ Family History ○ Hyperlipidemia ○ Hypertension ○ Other

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

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

7. 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