CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—PARKINSON'S DISEASE

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 were you first consulted for symptoms resulting in the diagnosis of Parkinson's Disease, and at that time, how long had impairment been present? (dd/mmm/yy)

2. When was your patient first given a firm diagnosis of idiopathic Parkinson's Disease? (dd/mmm/yy) By whom?

3. Has your patient suffered any previous episode of this condition or any conditions leading to it or related to it? Please provide details.

4. Which features of Parkinson's Disease does your patient exhibit and when did these symptoms appear?

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5. a) Did Parkinson's Disease result from treatment for any other illness, or is it associated with any other disease (ie. Atherosclerosis, supranuclear palsy)?

b) Did features of Parkinson's Disease occur as a side effect of a prescribed drug therapy or illicit drug use?

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

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