CRITICAL ILLNESS INSURANCE – CONFIDENTIAL PHYSICIAN'S REPORT—PARALYSIS

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. Please provide a brief outline of the medical history leading to your patient's paralysis.

2. When did you first see the patient for this condition? (dd/mmm/yy)

3. If paralysis was not a result of an accident, when did your patient first suffer symptoms or become aware of this condition?

4. Please describe the following:

a) Which limbs are affected?

b) Details of exact loss of function.

c) Residual use, if any, of his/her affected limbs.

d) The underlying cause of the condition.

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5.	Are there any treatments that could significantly improve the paralysis?

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

7.	Are you aware of any member of your patient's close family who has suffered from this or any similar condition?

8.	Please provide details of your patient's tobacco use, including amount per day and date last used.

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

10.	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