Assumption Life

Physician's Statement – Critical Illness Insurance
Cardiovascular Disorders
myocardial infarction (heart attack) – coronary artery bypass - aortic surgery – heart valve replacement or repair

For policies issued since July 2014

Claimant identification and authorization

First name _____ Last name _____

Policy number _____ Date of birth (DD/MM/YYYY) _____/_____/_____

I hereby authorize the release to Assumption Life of any information with respect to this claim.

I agree that a photocopy of this authorization shall be as valid as the original.

I understand that I am responsible for any charges related to medical reports or the completion of forms.

Claimant's signature _____ Date (DD/MM/YYYY) _____

If the policy owner and the claimant are not the same person, both signatures are required:

Owner's signature _____ Date (DD/MM/YYYY) _____

General information

PLEASE ANSWER ALL QUESTIONS AND INCLUDE REQUESTED SUPPORTING DOCUMENTS.

1. Date of first consultation (DD/MM/YYYY) _____/_____/_____
2. Date of onset of first symptoms (DD/MM/YYYY) _____/_____/_____
3. Description of first symptoms _____
   _____
   _____
4. Names and addresses of other physicians consulted and all hospitals attended by the patient:

Name and Address of Physician or Hospital	Consultation Date / Hospitalization Date*	Medical Problem

***Please include a copy of consultation reports and hospital discharge summaries.**

5. Date patient was advised of his/her diagnosis (DD/MM/YYYY) _____/_____/_____
6. By whom was the diagnosis made? _____
7. Does the patient have any family history of heart disease, stroke, cancer, diabetes or renal problems? ❑ Yes ❑ No
   If yes, provide details: _____
   _____
   _____
8. Details concerning the patient's use of tobacco or nicotine products, including quantity consumed daily as well as the date patient stopped using nicotine/tobacco products _____
   _____

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life
770 Main St. / P.O. Box 160, Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 506-853-5459

For patient having suffered a myocardial infarction

1. Has a myocardial infarction been diagnosed? ❑ Yes ❑ No Date diagnosed (DD/MM/YYYY) _____/_____/_____
2. Secondary diagnosis _____ Date diagnosed (DD/MM/YYYY) _____/_____/_____
3. Provide details relating to underlying causes, if any: _____
4. Details regarding the results of biochemical cardiac markers (type and levels) _____
   _____
   _____
5. Were changes noted on the ECG indicating a heart attack? ❑ Yes ❑ No

Please include copies of ECG tracings, results of biochemical cardiac markers, and other medical investigations done in relation to this diagnosis.

For patient having had coronary artery bypass surgery, aortic surgery, heart valve replacement or repair

1. Diagnosis _____ Date diagnosed (DD/MM/YYYY) _____/_____/_____
2. Secondary diagnosis _____ Date diagnosed (DD/MM/YYYY) _____/_____/_____
3. Provide details relating to any underlying causes: _____
   _____
4. Surgeon's name _____
5. Date of surgery (DD/MM/YYYY) _____/_____/_____
6. Name and address of hospital where surgery was performed _____
7. Type of surgery performed and details (number and placement of grafts, which heart valve was involved, etc.) _____
   _____
   _____

Please include the surgical report.

Physician's declaration and signature

According to the insurance contract, the term physician means "an individual who holds a valid license from the College of Physicians and Surgeons from the province or territory within which he is practicing in Canada or a valid license in the United States to practice medicine and treat illnesses and injuries, and who practices under the terms of that license. Physician does not include the insured, the owner, or a person who is a member of the insured's or owner's immediate family, nor an individual who holds any other health-related license or degree".

To that effect, we ask the following question: Are you a member of the insured's (claimant's) or policy owner's immediate family? ❑ Yes ❑ No

Physician's Name (in block letters)		Address		
Signature	Date (dd/mm/yyyy)	Telephone	Fax	Specialty

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