Assumption Life

Physician's Statement – Critical Illness Insurance
Kidney Failure - Major Organ Failure on Waiting List - Major Organ Transplant

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 diagnosed with kidney failure and needing dialysis

1. Date of diagnosis (DD/MM/YYYY) _____/_____/_____
2. Who advised the patient of the diagnosis? _____
3. Cause of kidney failure_____
   _____
   _____
4. Does the patient have end-stage irreversible failure of both kidneys? ☐ Yes ☐ No
5. Date dialysis began (DD/MM/YYYY) _____/_____/_____
6. Type of dialysis and frequency_____
7. Does the patient have any family history of kidney failure? ☐ Yes ☐ No
8. If yes, provide details:
   _____
   _____

For major organ transplant recipient or for patient diagnosed with major organ failure and currently awaiting transplant

1. Diagnosis _____ Date diagnosed (DD/MM/YYYY) _____/_____/_____
2. Secondary diagnosis _____ Date diagnosed (DD/MM/YYYY) _____/_____/_____
3. Is this failure irreversible? ☐ Yes ☐ No
4. Provide details relating to underlying causes, if any _____
5. Date patient was advised he/she was suffering from major organ failure (DD/MM/YYYY) _____/_____/_____
6. Date of patient's first consultation at the transplant centre (DD/MM/YYYY) _____/_____/_____
7. Name of the transplant centre _____
8. Date patient's name was added to transplant list (DD/MM/YYYY) _____/_____/_____
9. Date of transplant (DD/MM/YYYY) _____/_____/_____
10. Type of transplant: ☐ heart ☐ lung ☐ liver ☐ kidney ☐ bone marrow
11. Surgeon's name _____

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

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