

Physician's Statement – Critical Illness Insurance Blindness - Accidental Loss of Limbs

For policies issued since July 2014

Claimant identification and authorization								
First name Last name								
Pol	icy number							
I he	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							
PLE	PLEASE ANSWER ALL QUESTIONS AND INCLUDE REQUESTED SUPPORTING DOCUMENTS.							
1. 2. 3.	Date of first consultation (DD/MM/YYYY)							
4.	Names and addresses of other physicians consulted and all hospitals attended by the patient:							
I	Name and Address of Physician or Hospital Consultation Date / Hospitalization Date* Medical Problem							
*PI	ease include a copy of consultation reports and hospital discharge summaries.							
5.								
6.	By whom was the diagnosis made?							
7.								
	-							
8.	Details concerning the patient's use of tobacco or nicotine products, including quantity consumed daily as well as the date patient stopp using nicotine/tobacco products							

		For patient suffering	from blindness				
1.	What is the corrected vision? Right eye Left eye Both eyes	Date test was performed (DI	D/MM/YYYY)				
2.	What is the field of vision? Right eye Left eye	Date test was performed (DI	D/MM/YYYY)				
3.	Cause of blindness						
	If due to an accident, provide dat	te (DD/MM/YYYY):	and circ	cumstances of the	e accident:		
4.	. Were there any predisposing conditions or risk factors for developing blindness? No If yes, provide details:						
5.	i. Is the loss of vision in both eyes total and irreversible?						
6.	Is there any treatment that could improve this patient's vision? Yes No If yes, describe the treatment and indicate whether the patient is being or will be assessed for this treatment:						
7.	. Is there a family history of eye disorders? Yes No If yes provide details:						
		For patient having suffered a	n accidental loss of	limbs			
1. 2.		Y)					
3.							
4. 5.		<i></i>					
		Physician's declarati	on and signature				
fro and the	m the province or territory within d injuries, and who practices under e insured's or owner's immediate fa	the term physician means "an individua which he is practicing in Canada or a value the terms of that license. Physician do amily, nor an individual who holds any of destion: Are you a member of the insu	alid license in the Uni pes not include the ins other health-related l	ted States to pra sured, the owner icense or degree.	ctice medicine and treat illnesses , or a person who is a member of		
Physician's Name (in block letters)			Address	Address			
	nature		Telephone	 Fax	Specialty		