500-5000 Yonge Street
Toronto, ON M2N 7J8
Telephone: 1-800-846-5970
Fax: 416-883-5715

*Critical*ADVANTAGE™ Claimant's Statement

PLEASE PRINT IN INK

If someone other than the claimant has completed this form or part of this form, please give full name and relationship to claimant:

Claimant's Surname: _____ First Name: _____

Policy Number: _____ Date of Birth: D D / M M / Y Y Y Y

Phone Numbers

Address: _____ Home: _____

_____ Office: _____

Email: _____ Cell: _____

Occupation: _____ Last date worked: D D / M M / Y Y Y Y

On what date did symptoms begin? D D / M M / Y Y Y Y

Describe your symptoms: _____

_____

On what date were you advised of the diagnosis? D D / M M / Y Y Y Y

If claiming for a **surgical procedure**, on what date did the surgery take place? D D / M M / Y Y Y Y

---

1 Please give dates and describe the onset and nature of your condition: _____

_____

_____

2 On what date did you first consult a doctor for this condition? D D / M M / Y Y Y Y

3 What is the name and address of the doctor? _____

_____

4 Was this your usual medical attendant? ○ Yes ○ No

If ***"No,"*** who referred you to this doctor? _____

5 What tests were conducted to diagnose your condition? _____

_____

6 What is your current treatment and on what date did it begin? _____

_____

7 Have you previously suffered from, or received treatment for, a similar or related condition? ○ Yes ○ No

If ***"Yes,"*** give full details and dates for each episode: _____

_____

_____

8 Have any of your blood relatives suffered from a similar or related illness? ○ Yes ○ No

If ***"Yes,"*** state relationship of relative, nature of illness and the age and year at which the illness was diagnosed: _____

_____

_____

9 Have you had any HIV Tests? ○ Yes ○ No If ***"Yes"*** please provide latest date: D D / M M / Y Y Y Y Result: ○ positive ○ negative
If ***"No"*** has one been scheduled? ○ Yes ○ No If ***"Yes"*** please provide date: D D / M M / Y Y Y Y

10 a) Do you use nicotine products? ○ Yes ○ No
If ***"Yes"*** describe the type, your daily consumption and state how long you have been using them:

b) If ***"No"*** have you ever used nicotine products, and if so what was your daily consumption and when did you stop?

11 Please give names, addresses and telephone numbers of all physicians who have treated you or hospitals at which you have been treated for this condition.

NAME OF DOCTOR	ADDRESS (NUMBER, STREET, CITY, PROVINCE, POSTAL CODE)	TELEPHONE NO. INCLUDING AREA CODE	DATES SEEN
			D D / M M / Y Y Y Y
			D D / M M / Y Y Y Y
			D D / M M / Y Y Y Y

NAME OF HOSPITAL	ADDRESS (NUMBER, STREET, CITY, PROVINCE, POSTAL CODE)	TELEPHONE NO. INCLUDING AREA CODE	ADMISSION DATE	DISCHARGE DATE
			D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
			D D / M M / Y Y Y Y	D D / M M / Y Y Y Y

12 If not already provided above, please give the name, address and phone number of your family physician in Canada:

13 Are you insured for benefits related to this condition from another company? ○ Yes ○ No If ***"Yes"*** please indicate:

NAME OF INSURER	POLICY NUMBER	TYPE OF BENEFIT	AMOUNT OF BENEFIT INSURED	HAS A CLAIM BEEN SUBMITTED?
			$	○ Yes ○ No
			$	○ Yes ○ No
			$	○ Yes ○ No

AUTHORIZATION:

I authorize *ivari* to conduct the necessary investigations and to collect my personal information. I understand that the company will create and maintain files that will contain my personal information. I also understand that access to my personal information will be provided only to the company employees and to any other individual contracted by the company, during the conduct of their work, or to individuals to whom I gave access in writing, or to any other legally authorized individual.

Moreover, I understand that, unless my access to my personal information is legally restricted by the company, I would be authorized to review copies of any document containing such personal information that is held by the company, subject to the payment of a reasonable reproduction fee.

I authorize any medical practitioner, hospital, clinic, pharmacy or medically related facility, insurance company, government agency, provincial health insurer, or any organization or person that has records or data regarding me or my minor child to give to *ivari*, its Reinsurers and legal representatives, all such information.

I authorize *ivari* to access, copy and review any other files it has relating to me.

This Authorization will remain valid for the duration of the claim. A Photostat copy or facsimile of this Authorization shall be as valid as the original.

I understand that completion of this form does not constitute acceptance of the claim by *ivari*.

Claimant's signature Date: D D / M M / Y Y Y Y