NATIONAL BANK INSURANCE

CLAIM REQUEST
Critical illness insurance
Cancer
Declaration by Attending Physician

IDENTIFICATION OF INSURED

Loan/Policy No. _____ Transit _____

Surname at birth _____ Date of birth (YYYY MM DD) _____

First name _____ ☐ M ☐ F Sex

DECLARATION OF ATTENDING PHYSICIAN

1. a) When did the patient first show symptoms? _____ Date (YYYY MM DD)

   Describe the symptoms and provide details.

   _____

   _____

   b) Date of first consultation for this condition: _____ Date (YYYY MM DD)

   c) How long have you been treating this patient? _____ Date (YYYY MM DD)

2. a) When was cancer diagnosed? _____ Date (YYYY MM DD)

   b) Specify the type of cancer: _____

   c) What was used to diagnose the cancer (e.g. MRI, CAT scan)?

   _____

   _____

   d) When was the patient informed of the diagnosis? _____ Date (YYYY MM DD)

   e) Who notified the patient? _____

3. Please provide a copy of the pathology reports complete with the following information:

   - type of tumour _____

     _____

   - location of tumour _____

     _____

   - histology and staging _____

     _____

4. Please list the names and address of any other physicians consulted by the patient or hospitals where he or she received treatment for this cancer.

Name of physician or hospital	**Address** (No., Street, City, Province, Postal code)	**From** (YYYY MM DD)	**To** (YYYY MM DD)

CONTINUE ON PAGE 2

30704-512 (2016-06-07)

5. a) Has the patient ever had cancer or a health-related problem that may have contributed to his/her illness?

☐ Yes ☐ No

If so, please provide dates and any relevant information.

b) Has the patient been tested for Human Immunodeficiency Virus (HIV)?

Date (YYYY MM DD)	Result:
Date (YYYY MM DD)	Result:

6. a) Does the patient have a family history of cancer, diabetes, stroke or heart disease before the age of 60? Please provide details.

b) Please provide information on any other major illness in the family.

7. Please provide details of the patient's use of tobacco, marijuana, e-cigarettes and nicotine substitutes, including the quantity consumed daily, as well as the date when he stopped using tobacco.

8. Please include any other relevant information that could be useful in assessing the patient's claim request.

Please attach copies of any report prepared by a specialist or hospital for examination by our medical expert.

SIGNATURE OF THE ATTENDING PHYSICIAN

Name and address (in block letters):

Specialty:

Telephone No.:

Signature

Date (YYYY MM DD)

The patient is responsible for completing this form and assuming any applicable costs.