NATIONAL BANK INSURANCE

Insurer: National Bank Life Insurance Company

CLAIM REQUEST
LIFE INSURANCE

Declaration of attending physician

INFORMATION

Transit No.

	Loan, policy or card number	Loan, policy or card number
☐ Personal Loan		
☐ Mortgage loan		
☐ Line of credit		
☐ Commercial loan		
☐ Life insurance without medical exam		
☐ Individual Insurance		
☐ Master Card credit card		

IDENTIFICATION OF THE DECEASED

Surname (maiden name if applicable)

Given name

Sex ☐ M ☐ F

PHYSICIAN'S STATEMENT (Family physician? ☐ yes ☐ no)

Date of birth Y M D

Date of death Y M D

1. How long have you been treating this patient? _____

2. Place of death (If death occurred in a hospital or other institution, provide the name) _____

3. Cause of death

Illness or condition that caused the death (not the way death occurred, such as a heart attack, asthenia, etc., but the illness, injury or complication that was the cause of death)

a) _____

Interval between the onset of illness and death

b) _____

Previous causes (disabling state, if any, that was the origin of the immediate cause of death)

c) _____

4. Was death caused by : suicide ? ☐ yes ☐ no homicide ? ☐ yes ☐ no accident ? ☐ yes ☐ no

Was there : coroner's inquest ? ☐ yes ☐ no an autopsy ? ☐ yes ☐ no

What were the results? _____

5. Please provide details of the patient's use of tobacco, including the quantity consumed daily, as well as the date when he stopped using tobacco. _____

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6. In the past five (5) years has the patient consulted a health care professional, had a medical examination or follow-up, suffered or been diagnosed with or treated for any of the following problems: heart disease or circulatory disorders, blood disorders including cholesterol, blood pressure disorders, tumors or cancer, muscular dystrophy, multiple sclerosis, AIDS, Human Immunodeficiency Virus or any other disease or disorder of the immune system, chest pains or angina, lung disease or respiratory problems, digestive problems, liver disorders, intestinal disorders, kidney disease, urinary tract disorders, genital disorders, nervous system disorders, diabetes, or psychiatric or psychological disorders ?

Don't know ☐ No ☐ Yes ☐ **If yes, please mention the name of the disease, the dates of consultations, the treatments received, the hospitalization periods, if applicable, and the date when the patient was informed about the disease :**

SIGNATURE OF THE PHYSICIAN

Physician's surname and given name _____

Address (no., street, apt., city, province, postal code) _____

_____

Telephone ( ) |_|_|_|_|_|_|_|

Signature of physician _____ Date |_|_|_|_|_|_|_|_| Y M D

N.B. The deceased's estate is responsible for the fees charged for the completion of this form.