NATIONAL BANK INSURANCE

CLAIM REQUEST
Critical illness insurance
Stroke
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) Date of first consultation: _____ Date (YYYY MM DD)

   b) How long has this patient been in your care? _____

2. a) Has a stroke been diagnosed? ☐ Yes ☐ No

   b) Date of the stroke. _____ Date (YYYY MM DD)

   c) Describe the cause of the stroke.

   _____

   _____

   d) Describe any residual neurological effects.

   _____

   _____

   e) How long did the neurological effects last? _____

   f) Who made this diagnosis? _____

Please attach a copy of the computerized axial tomography (CAT) scan or magnetic resonance imaging (MRI), if available.

3. a) When was the patient informed of the diagnosis? _____ Date (YYYY MM DD)

   b) Who notified the patient? _____

4. a) Please indicate the name and address of any other physician consulted by the patient or the name and address of any hospital where the patient was treated for this stroke.

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

   b) List any other examinations or observations and provide details.

   _____

   _____

   _____

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5. When did the patient have a stroke or first show symptoms of having had a stroke?

Date (YYYY MM DD)

Provide details and describe symptoms.

6. Please describe any predisposing condition or risk factor associated with the patient's stroke, and include dates:

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

8. 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.

9. 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):

Speciality:

Telephone No.:

Signature

Date (YYYY MM DD)

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