NATIONAL BANK INSURANCE

CLAIM REQUEST

Critical Illness Insurance
Declaration by the Insured

IDENTIFICATION OF INSURED

Loan/Policy No. | Transit No.

Surname at birth | Date of birth

First name | Sex ☐ M ☐ F

INFORMATION ABOUT CLAIM

1. Address (No., Street, City, Province) _____ Postal Code

2. a) Please provide a brief description of the nature and seriousness of your illness.

b) First sign of symptoms. Y M D

Please describe the symptoms.

c) Date of first consultation with physician for this illness. Y M D

Please indicate the name and address of the attending physician:

Name and address: _____

Telephone No.: ( ) -

d) Have you undergone tests, examinations, observation or surgical procedures to treat this illness? If so, please indicate the dates and provide details.

e) Have you ever suffered from a similar or related illness, or have you been treated for a similar or related illness?
☐ Yes ☐ No
If so, please indicate the dates and provide details.

MEDICAL CONSULTATION

3. a) Please indicate the name and address of the attending physician.

Name and address: _____

Telephone no.: ( ) -

b) Please provide details about any other medical specialist or health professional you have consulted with respect to this illness.

Name	Address (No., Street, City, Province, Postal code)	Telephone No.	Date consulted		
			Y	M	D
		( )			
		( )			
		( )			

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c) Names and addresses of all physicians or health care professionals (chiropractors, physiotherapists, psychologists, etc.) you consulted, and that treated you during **the last 5 years. Please indicate the reason(s) for each consultation, whether or not they are related to your present condition**. If no consultations and/or medical treatments, please indicate this clearly in the space provided below. If more than 3 consultations, please attached a separate sheet.

Name and address of the physician or health professional	**Consultation or treatment dates**			**Reason of the consultation**	**Treatment prescribed** (medication, chiro, physio, rest, surgery etc.)
	Y	**M**	**D**		

d) What other type of treatment have you received or are you currently receiving for this type of illness (e.g. medications, therapy, etc.)?

GENERAL INFORMATION

4. a) Have any of your blood relatives ever suffered from a similar or related illness? ☐ Yes ☐ No

Relationship	Nature of illness	Age when illness was first diagnosed

b) As one or more members of your biological family (father, mother, brothers or sisters) suffered from diabetes, cancer, a stroke or heart disease before the age of 60? ☐ Yes ☐ No

If so, please provide details:_____

c) Do you have insurance coverage with another company for this health condition? ☐ Yes ☐ No

Insurer	Type of coverage	Amount of coverage	Has a claim request been submitted?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

d) Have you used tobacco, marijuana, e-cigarettes and nicotine substitutes in the past 12 months? ☐ Yes ☐ No

- If so, please indicate the type of product and the quantity consumed each day: _____

  Indicate the date on which you began using these products. Y M D

- If not, have you ever used tobacco, marijuana or e-cigarettes products in the past? ☐ Yes ☐ No

  Indicate the date on which you stopped using these products. Y M D

e) Please provide any additional information that could support your claim request.

SIGNATURE OF INSURED

I hereby certify that the declarations made in this claim request are complete and accurate.

Signature _____ Date Y M D

To prevent delays in processing your claim, please make sure that all questions have been answered.