NATIONAL BANK INSURANCE

CLAIM REQUEST
FIRST DIAGNOSIS OF CANCER

DECLARATION OF ATTENDING PHYSICIAN

CREDIT CARD INFORMATION

_____ The claim concerns:
Mastercard account No.

☐ Cardholder ☐ Insured spouse

IDENTIFICATION OF INSURED

_____
Last name (maiden name if applicable)

_____ Sex: ☐ M ☐ F _____
First name Date of birth (YYYY MM DD)

DECLARATION OF ATTENDING PHYSICIAN

The purpose of this statement is to help us establish the degree of disability. Would you therefore please provide sufficient details regarding the history of the illness, your observations, your diagnosis, treatment prescribed and results obtained.

1- DATE OF BIRTH _____
(YYYY MM DD)

2- DIAGNOSIS (INCLUDING COMPLICATIONS)

a) Diagnosis _____ b) Stage of illness (TNM): _____

c) Date diagnosis was made: _____ d) Spécifier à l'aide de quel examen diagnostique (Rx, imagerie, ct-scan) : _____
(YYYY MM DD)

e) Date of biopsy during which the cancer diagnosis was supported by the opinion of a pathologist who is a member of an association duly recognized in Canada: _____ **Please provide a copy of the biopsy results if available.**
(YYYY MM DD)

f) Was this the first diagnosis? ☐ Yes ☐ No If no, when was cancer first detected in the patient: _____
(YYYY MM DD)

g) Date of first visit: _____ Date of last examination: _____
(YYYY MM DD) (YYYY MM DD)

h) Date of next visit: _____ Frequency of visits: _____
(YYYY MM DD)

i) As of what date do you consider this patient to have been totally disabled? _____
(YYYY MM DD)

3- PAST HISTORY: CANCER

a) Date symptoms appeared: _____
(YYYY MM DD)

b) Prior to this total disability, for the same illnesses described above, did the patient:

- receive medial treatment? ☐ no ☐ yes specify periods (dates): _____
- consult a physician? ☐ no ☐ yes specify periods (dates): _____
- undergo examinations? ☐ no ☐ yes specify periods (dates): _____
- use medication? ☐ no ☐ yes specify periods (dates): _____
- become hospitalized? ☐ no ☐ yes specify periods (dates): _____

4- NATURE DU TRAITEMENT

a) ☐ Rest ☐ Chemotherapy ☐ Radiotherapy ☐ None ☐ Other ☐ Hospitalization

Date active treatments started _____ Frequency _____ Date ended _____
(YYYY MM DD) (YYYY MM DD)

b) Surgery performed? ☐ Yes ☐ No When? _____
(YYYY MM DD)

Surgery planned? ☐ Yes ☐ No When? _____
(YYYY MM DD)

Description: _____

c) Is the patient following the recommended treatment? ☐ No ☐ Yes

SIGNATURE OF ATTENDING PHYSICIAN

First and last name *(please print)*: _____

Specialization: _____

Address: _____

Telephone No.: _____

Signature **X** _____ Date: _____
(YYYY MM DD)

The patient is responsible for having his/her physician complete this form and paying any relates charges.

RESERVED FOR ADMINISTRATIVE USE

Authorized signature: **X** _____ Date: _____
(YYYY MM DD)