HUMANIA ASSURANCE MD®

Critical Illness Physician's Statement (stroke)

Part 1 - Insured's Information

Policy no.: ☐☐☐☐☐☐☐☐☐

Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date: ☐☐☐☐ / ☐☐ / ☐☐
year / month / day

Phone no.: ☐☐☐ ☐☐☐ ☐☐☐☐

I hereby authorize the disclosure of any information related to my claim to my insurer, Humania Assurance Inc.

Date: ☐☐☐☐ / ☐☐ / ☐☐ Signature: ____________________
year / month / day

Part 2 - Attending Physician's Statement

1. a) Has the patient ever had a stroke? ☐ Yes ☐ No

   b) Was the stroke caused by a cerebral infarction, hemorrhage, embolism or aneurysm?

   ☐ Yes ☐ No

   Please provide details: ____________________

   ____

   c) Did the stroke cause neurological deterioration leading to an objective and measurable handicap?

   ☐ Yes ☐ No

   If yes, did the neurological deterioration last for a period of 30 days after the stroke occurred?

   ☐ Yes ☐ No

2 . a) Nature of the neurological deterioration: ____________________

   ____

   b) Is the neurological deterioration ilikely to be permanent? ☐ Yes ☐ No

4300-048-en
2017/02

Part 2 - Attending Physician's Statement (cont.)

Please provide details: ______

3 . a) Date of first symptoms: year / month / day

b) Date on which the patient first consulted a physician about this problem: year / month / day

c) Date on which the patient first consulted you about this problem: year / month / day

d) Date on which the stroke occurred: year / month / day

e) Date on which the patient first became aware of this problem: year / month / day

4. Does the patient have a history of underlying health conditions or neurological problems? ☐ Yes ☐ No

If yes, please provide details: ______

5. Do you know if any of the patient's immediate family members have had any neurological conditions or if they have undergone any exams for neurological problems? ☐ Yes ☐ No

If yes, please provide details: ______

6. Has the patient consulted any other doctors or been hospitalized for this or a related health problem? ☐ Yes ☐ No

If yes, please provide the names and addresses: ______

7. Primary diagnosis: ______

Secondary diagnosis: ______

Contributing factors: ______

8. Please describe in detail the health condition that caused the patient's stroke:

Part 2 - Attending Physician's Statement (cont.)

9. Has the patient undergone other exams, tests or treatments? ☐ Yes ☐ No

   If yes, please provide details: ____________________

10. Does the patient smoke? ☐ Yes ☐ No

    If no, did the patient previously smoke? ☐ Yes ☐ No

    If yes, please provide information on the patient's smoking history: ____________________

11. Provide details on any health problems (related to the current illness or not) for which the patient has received treatment from you or another physician.

    ____

Please enclose copies of any specialist, hospital or pathology reports, tests, analyses or other similar supporting documentation for the patient's claim.

Part 3 - Attending Physician's Information

Last name:

First name:

Specialty: ____________________

Address:
(civic address) (office)

City:

Province: Postal Code:

Phone number:

Date: year / month / day Signature: ____________________

It is the insured's responsibility to have this form completed and cover any associated fees.

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6