Desjardins Insurance
Life • Health• Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

CRITICAL ILLNESS CLAIM FORM
(CANCER - HEART ATTACK - STROKE OR OTHER ILLNESS)
Attending physician's statement

Print | Reset

Instructions

Section A must be completed by the insured. Sections B, C, D and E must be completed by the insured's attending physician or the specialist who diagnosed the critical illness.

Critical Illness insurance covers the insured in the event that s/he is diagnosed with one of the critical illnesses listed in his/her contract and according to certain specific criteria or conditions. For this reason, it is very important that we obtain detailed information on the insured's condition so that we may review the claim properly. The purpose of this type of insurance coverage is to help the insured overcome difficulties stemming from the diagnosis of a critical illness.

We are counting on your cooperation to send us the information requested as soon as possible so that we may review this claim. Kindly enclose the additional documents requested with this form.

Fees charged for this statement are to be paid by the insured.

Section A - Identification (to be completed by insured)

☐ Individual Insurance	Contract no.		
☐ GetWell Insurance	Contract no.		
☐ Group Insurance	Name of employer	Contract no.	Identification no.

Last name	First name	Date of birth YYYY - MM - DD

Address - no., street | City | Province | Postal code

Telephone nos. Home: Area code + number Work: Area code + number

Section B - General information

Name of physician	Specialty
Since when have you been following this patient? YYYY - MM - DD	Critical illness diagnosis

When did the symptoms first appear? YYYY - MM - DD	Date of first appointment YYYY - MM - DD	Date of diagnosis YYYY - MM - DD	When was this person first informed of the illness? YYYY - MM - DD

Name and address of hospitals consulted	Name and address of physicians consulted	Date
		YYYY - MM - DD
		YYYY - MM - DD

Does the patient use tobacco or a tobacco substitute? ☐ Yes ☐ No
Has the patient ever used tobacco or a tobacco substitute? ☐ Yes ☐ No **If "Yes"**, date stopped: YYYY - MM - DD

Do any family members (father, mother, brother, sister, grandfather, grandmother, uncle or aunt) suffer from or have any of them ever suffered from a hereditary illness? **If "Yes"**, complete the table: ☐ Yes ☐ No

Family member	Relationship	Illnesses	Age at onset of illness	Age if still living	Age at death

Over the last 5 years, has the patient received care, treatment or services, consulted a physician or been prescribed drugs for this illness or any other condition? ☐ Yes ☐ No
If "Yes", complete the table:

Illnesses	Dates	Results	Hospitalization periods	When was the patient informed of the illness?
	YYYY - MM - DD			YYYY - MM - DD
	YYYY - MM - DD			YYYY - MM - DD
	YYYY - MM - DD			YYYY - MM - DD

Section C - Details of Diagnosis (describe symptoms in Section D)

☐ **Cancer**
Enclose a copy of the complete medical file, including the pathology report for the biopsy that led to the diagnosis.

Anatomopathological diagnosis:

Cancer site:

Cancer stage (I to IV or A to D, as applicable):

Is this a recurrence? ☐ Yes ☐ No	Date of recurrence YYYY-MM-DD

☐ **Heart attack / Myocardial infarction**
Enclose a copy of the complete medical file, including test, bloodwork and ECG results and the hospital discharge summary.

Any rises and falls of biochemical cardiac markers to levels considered diagnostic of myocardial infarction?	☐ Yes ☐ No
Any new electrocardiogram (ECG) changes consistent with a myocardial infarction?	☐ Yes ☐ No
Is this your patient's first myocardial infarction?	☐ Yes ☐ No
Any new Q waves during or immediately following an intra-arterial cardiac procedure, including an angiography, an angioplasty or other procedure?	☐ Yes ☐ No

☐ **Stroke / Cerebrovascular accident**
Enclose a copy of the complete medical file, including test results and the hospital discharge summary.

Is this your patient's first cerebrovascular accident? ☐ Yes ☐ No	Date of cerebrovascular accident YYYY-MM-DD

Have any neurological deficits persisted for more than 30 days after the diagnosis?	☐ Yes ☐ No

If so, describe the residual neurological deficits after 30 days.

Was the cerebrovascular accident caused by a trauma?	☐ Yes ☐ No

If so, describe the trauma.

☐ **Other illness**
Enclose a copy of the complete medical file, including test results and the hospital discharge summary.

Section D - Description of Symptoms, Comments and Additional Details

Please provide any information you feel would be relevant to our review of your patient's claim for benefits.

Section E - Identification of physician

Address of physician	Signature of Physician
	Licence no.
Postal code	Date YYYY-MM-DD
Telephone no. Area code + number	Fax no. Area code + number