HUMANIA ASSURANCE MD®

Critical Illness Physician's Statement (autism)

Part 1 - Insured's Information

Policy no.:

Last name:

First name:

Birth date: year / month / day

Phone number:

I hereby authorize my physician to disclose to my insurer any information about me related to this claim, **including consultation reports**.

Date: year / month / day Signature:

Part 2 - Attending Physician's Statement

In order for us to accurately review this claim, all questions must be answered in full.

According to the information in our files, the patient suffers from pervasive developmental disorder. Please specify the exact nature and severity of the disorder (e.g. Kanner's syndrome, Rett's syndrome, Asperger's syndrome, etc.):

Please list the dates of each visit as well as the reasons for each consultation:

4300-061-en
2017/02

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

Please describe in detail how the condition has evolved and how it has been impacting the patient's development:

Please provide all other relevant information to this claim:

Please 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 provide the name and address of the neurologist who confirmed the diagnosis.

Physician's name:	**Address**

Please provide the names and addresses of the other physicians the patient consulted or of hospitals where the patient has been admitted for issues related to this diagnosis:

Name of the physician or hospital	**Address**	**From** (YEAR/MM/DD)	**To** (YEAR/MM/DD)

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

Please enclose the following documents:

- ☐ a copy of the imaging report confirming the diagnosis
- ☐ a copy of any specialists' reports related to this diagnosis
- ☐ a copy of any hospital reports related to this diagnosis
- ☐ a copy of all test results related to this diagnosis

Part 3 - Attending Physician's Information

Specialty: _____

Last name:

First name:

Address:
(civic address) (apt.)

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