HUMANIA ASSURANCE MD®

Critical Illness Physician's Statement (deafness)

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.

On what date did the patient first show symptoms of or become aware of any hearing loss? year / month / day

What were these symptoms?

On what date did the patient first consult you regarding hearing impairment or other related issues? year / month / day

How long has the insured been your patient?

Describe the patient's clinical progress and list the neurological signs and symptoms complete with dates and their duration.

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

On what date did you tell the patient that he/she could possibly be diagnosed with deafness?

year / month / day

What is the auditory threshold in each ear? Right: Left:

Please specify the date of the first audiogram that determined these auditory thresholds.

year / month / day

What was the cause of the hearing loss?

Is there any treatment that could improve the patient's hearing?

Is the hearing loss permanent? ☐ Yes ☐ No

Is there a history of hearing loss in the patient's family? ☐ Yes ☐ No

Are there any other significant conditions in the patient's family medical history? ☐ Yes ☐ No

If yes, please specify.

Please include any other information that is relevant to processing this claim.

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:

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 ENT specialist (otorhinolaryngologist) who confirmed the diagnosis.

Physician's name:	Address

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

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)

Please enclose the following documents:

- ☐ a copy of the audiogram
- ☐ a copy of the imaging report confirming the diagnosis
- ☐ a copy of any specialists' reports related to this diagnosis
- ☐ a copy of any hospital files 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

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