HUMANIA ASSURANCE MD®

Critical Illness Physician's Statement (multiple sclerosis)

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:

Partie 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 exhibit symptoms of multiple sclerosis? year / month / day

What were these symptoms?

On what date did the patient first consult you about this condition? 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.

4300-060-en
2017/02

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

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

year / month / day

Is there a history of multiple sclerosis 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 describe the current treatment.

Please describe the most recent neurological findings.

Please rate the patient's condition based on the EDSS scale.

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 neurologist 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 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: Signature:
year / month / day

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