HUMANIA ASSURANCE MD®

Critical Illness Physician's Statement (heart attack)

Part 1 - Insured's Information

Policy no.:

Last name:

First Name:

Date of birth: Year / Month / Day

Phone no.:

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

Date: Year / Month / Day Signature:

Part 2 - Attending Physician's Statement

1. a) Has the patient experienced chest pain? ☐ Yes ☐ No

   b) Was the chest pain associated with recent findings in the electrocardiogram (ECG) and consisting of Q waves and localized T-wave inversions? ☐ Yes ☐ No

   c) Was there an abnormal increase in the patient's cardiac enzymes? ☐ Yes ☐ No

2. 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 patient first became aware of this problem: Year / Month / Day

3. Does the patient have a history of heart problems or other underlying health conditions? ☐ Yes ☐ No

   If yes, please provide details.

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2017/02

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

4. Do you know if any of the patient's immediate family members have suffered from the same or similar health problems? ☐ Yes ☐ No

   If yes, please provide details.

5. Did the patient consult any other doctors or was he/she hospitalized for this condition or any other related health problem? ☐ Yes ☐ No

   If yes, please provide the names and addresses.

6. Primary diagnosis:

   Secondary diagnosis:

   Contributing factors:

7. a) Details regarding the chest pain:

7. b) Provide dates of previous ECGs and details and dates of new ECG findings. Please enclose copies of the ECGs performed at the time of the infarction.

7. c) Provide details on the cardiac enzyme test results (type and rates). Please enclose copies of the results.

8. Has the patient undergone other exams, tests or treatments (besides the ECG)? ☐ Yes ☐ No

   If yes, please provide details.

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

9. 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.

10. 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

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