HUMANIA ASSURANCE MD®

Critical Illness Insurance
Confidential Physician's Report
(Cancer)

Part 1 - Patient Authorization

Name:

First Name:

Address:

City:

Province: Postal Code:

Policy N°:

Date of birth: Year / Month / Day

Telephone N°:

I hereby authorize the release to my insurer of any information **INCLUDING CONSULTATION REPORTS** with respect to this claim.

Date: Year / Month / Day Patient's signature:

Part 2 - Physician's Report

1. a) On what date did your patient first have symptoms? What were they? Date: Year / Month / Day

   b) When did your patient first consult you for this condition? Date: Year / Month / Day

   c) How long has this person been your patient?

2. a) Please provide the date this cancer was diagnosed. Date: Year / Month / Day

   b) On what date was the patient advised of the diagnosis?

   By Whom?

4300-047-en
2018/06

Part 2 - Physician's Report (…continued)

3. Please provide a copy of the pathology report (and other reports as appropriate) giving the following details:
   - Type of Tumor
   - Site of Tumor
   - Histology and staging

4. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer:

Name of Physician or Hospital	**Address** (number, street, city, province, postal code)	**Date from** (Year/Month/Day)	**Date to** (Year/Month/Day)

5. Is there invasion or adjacent tissues? Are regional lymph nodes involved? Is there distant metastasis?

   If yes, please provide details. ______________________________

6. a) Has your patient previously suffered from cancer or any predisposing disorders?

   If so, please provide dates and details. ______________________________

   b) Has your patient ever been tested for the Human Immunodeficiency Virus?

   Date: ☐☐☐☐ / ☐☐ / ☐☐ (Year / Month / Day) Result: ______________________________

   Date: ☐☐☐☐ / ☐☐ / ☐☐ (Year / Month / Day) Result: ______________________________

7. Please provide any other information that would be helpful in the assessment of your patient's claim.

8. Does your patient smoke? ☐ Yes ☐ No

   If the answer is "No", has he ever smoked? ☐ Yes ☐ No

   If the answer is "Yes", please provide details of their smoking history: ______________________________

Part 2 - Physician’s Report (…continued)

9. Give details of health problems, whether or not related to the current illness, for which you or another doctor have treated your patient.

Please provide a copy of all specialist, hospital and pathology reports, tests, analyses or other similar evidence to support your patient's claim.

Part 3 - Please provide copies of any specialist or hospital reports

Speciality :

Name of attending physician:

Address:

(number and street

(apt./suite)

City:

Province: Postal Code:

Telephone N°:

Date: Year / Month / Day Signature:

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