Desjardins Insurance
Life • Health• Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2
www.desjardinslifeinsurance.com

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

CRITICAL ILLNESS CLAIM FORM
Attending physician's statement

PRINT RESET

Identification of insured

Last name		Date of birth
First name	Contract number	Claimant number

Fees charged for this statement and a copy of the record are to be paid by the insured.

A. Information about the illness

Diagnosis

Date of diagnosis: YYYY - MM - DD	Date of first symptoms: YYYY - MM - DD	Date of first consultation: YYYY - MM - DD

Since when have you been following this patient? YYYY - MM - DD

Name and address of physicians consulted	Place of consultation (Establishment names and addresses)	Date
		YYYY - MM - DD
		YYYY - MM - DD

B. Details of diagnosis – Describe symptoms in section C

☐ **Cancer**
Enclose a copy of the complete medical file, including the pathology report for the biopsy that led to the diagnosis.

Anatomopathological diagnosis:

Cancer site:	Cancer stage (I to IV or A to D, as applicable):

Is this the patient's first cancer diagnosis? ☐ Yes ☐ No If no, specify:

Previous diagnosis: _____ Date of this diagnosis: YYYY - MM - DD

Is this a recurrence? ☐ Yes ☐ No If yes, date of recurrence: YYYY - MM - DD

☐ **Hearth attack / Myocardial infarction**
Enclose a copy of the complete medical file, including test, bloodwork and ECG results and the hospital discharge summary.

Any rises and falls of biochemical cardiac markers to levels considered diagnostic of myocardial infarction?	☐ Yes ☐ No
Any new electrocardiogram (ECG) changes consistent with a myocardial infarction?	☐ Yes ☐ No
Is this you patient's first myocardial infarction?	☐ Yes ☐ No
Any new Q waves during or immediately following an intra-arterial cardiac procedure, including an angiography, an angioplasty or other procedure?	☐ Yes ☐ No

☐ **Stroke / Cerebrovascular accident**
Enclose a copy of the complete medical file, including test results and the hospital discharge summary.

Is this your patient's first cerebrovascular accident? ☐ Yes ☐ No	Date of cerebrovascular accident: YYYY - MM - DD

Have any neurological deficits persisted for more than 30 days after the diagnosis? ☐ Yes ☐ No If so, describe the residual neurological deficits after 30 days: _____

D3E (15-11)

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CRITICAL ILLNESS CLAIM FORM
Attending physician's statement (cont.)

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Identification of insured

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B. Details of diagnosis (cont.) – Describe symptoms in section C

Was the cerebrovascular accident caused by a trauma? ☐ Yes ☐ No If so, describe the trauma:

_____

_____

☐ **Other illness**
Enclose a copy of the complete medical file, including test results and the hospital discharge summary.

C. Description of symptoms, comments and additional details

Please provide any information you feel would be relevant to our review of your patient's claim for benefits.

D. Other information

Please answer the following question to the best of your knowledge. In the **past 5 years**, has your patient consulted or received treatment either from you or from another physician or healthcare professional, or taken medication?

☐ Yes ☐ No If yes, please indicate the following information:

Illnesses, injuries or health problems	Dates of consultation	Name of physician or healthcare professional consulted	Medication and examination results	Hospitalization periods
	YYYY - MM - DD			from: YYYY - MM - DD to: YYYY - MM - DD
	YYYY - MM - DD			from: YYYY - MM - DD to: YYYY - MM - DD

E. Identification of physician

Last name, first name: _____ Telephone: AREA CODE + NO.

License number: _____ Fax: AREA CODE + NO.

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: _____