Desjardins Insurance
Life • Health• Retirement

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

CRITICAL ILLNESS CLAIM FORM
Attending physician's statement

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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

☐ **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.

D301E (15-11)

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CRITICAL ILLNESS CLAIM FORM
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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 any 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: _____