Assumption Life

Critical Illness Claim
Claimant's Statement

Identification

Claimant's Name _____ Claimant's Last Name _____
Policy Number(s) _____ Date of Birth (DD/MM/YYYY) _____
Address _____
Telephone: Home _____ Cell. _____ Work _____

Information concerning your critical illness

1. a. Please indicate for which condition or injury you are submitting claim: _____
   b. Please provide a brief description of the nature and extent of your illness or injury: _____
   _____
   _____

2. a. Date of first symptoms_____
   b. Please describe first symptoms _____
   _____
   _____

3. a. Date of first medical consultation with regard to your illness or injury _____
   b. Date on which you were advised of diagnosis/of need for surgery _____

4. Name of regular attending physician _____

   Address: _____
   Number Street Apt.

   _____
   City Province Postal code

5. Please provide names of any other doctors consulted.

Name	Address	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. a. Have you undergone diagnostic tests, investigations or surgical treatments related to your condition or injury? ❑Yes ❑No
   b. If yes, please provide details, including dates.
   _____
   _____
   _____

7. a. If you have undergone treatments, examinations, or tests in a hospital or other medical facility, please provide us with the following:

Name of Hospital/Medical Facility	Address	Dates of Tests or Consultations
_____	_____	_____
_____	_____	_____
_____	_____	_____

   b. What other treatment have you received or are you currently receiving for your illness or injury? (i.e., medication, therapy, etc.)
   _____
   _____

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
770 Main St. / P.O. Box 160, Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 506-853-5459

8. a. Have you ever suffered from or received treatment for a similar or related illness? ❑Yes ❑No
   b. If yes, please provide details, including dates. _____
   _____
   _____

9. a. If this claim results from an accident, please provide the date of the accident: _____
   b. Please provide details and circumstances of accident: _____
   _____
   _____
   c. Please provide us with the name of the police officer and address of the police detachment: _____
   _____
   _____

10. a. If this claim results from an occupational/work-related injury, has a claim for compensation been submitted to your provincial Workers' Compensation Board? ❑Yes ❑No
    b. If yes, please provide name of case manager: _____

General information

1. a. Do you use any form of tobacco or nicotine products? ❑Yes ❑No ☐ No, but have consumed in the past
   b. If yes, how long have you been consuming these products? _____
   c. If yes, please indicate the type of product consumed and your daily consumption: _____
   d. If no, but consumed in the past, when did you quit? _____

2. a. Has your biological father, mother or a biological brother or sister ever suffered from a similar or related condition? ❑Yes ❑No
   b. If yes, please indicate the following:

Relationship	Name of condition	Date of diagnosis	Age at time of diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Declaration and authorization

I authorize Assumption Life, in the assessment of my claim, to obtain the necessary information from individuals or organizations holding personal information about me, including other insurers, other reinsurers, financial institutions, physicians, medical institutions and health care providers, employers or group insurance plan administrators, agents, representatives or brokers and all persons or organizations who may have personal information regarding my claim.

In addition, I authorize Assumption Life to provide necessary personal information about me to the above-mentioned individuals and organizations or to exchange this information with them.

I confirm that a photocopy or electronic version of this authorization has the same value as the original.

_____ _____

Date (DD/MM/YYYY) Claimant's Signature

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