Critical Illness Insurance – Physician's statement – ALS and Motor Neuron Disease

Sun Life Financial

Policy number

The patient is responsible for obtaining this form and any charges for its completion, unless prohibited by law.

1 Personal information – This section only is to be completed by the patient

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last name	First name	Gender ☐ Male ☐ Female
Provincial health insurance plan number			Date of birth (dd-mm-yyyy)
Address (street number and name)		Apartment or suite	City
Province	Postal code		Daytime telephone number

Authorization

I authorize any licensed physician, medical practitioner or health care professional who has observed me for diagnosis or treatment, any hospital, clinic or other medically related facility where I have been a patient, any public body, or any private health or social services establishment to release to Sun Life Assurance Company of Canada (Sun Life Financial) information needed to adjudicate and administer this claim. I authorize Sun Life Financial, its advisors and service providers to collect, use and exchange information needed for adjudicating and administering this claim with any person or organization who has relevant information pertaining to this claim including health professionals, government agencies, provincial health care plans, institutions, investigative agencies, insurers and reinsurers when Sun Life Financial deems it necessary for the purpose of adjudicating and administering this claim.

I understand this authorization is valid for the duration of this claim.

Date (dd-mm-yyyy)	Signature of patient X

A copy of this authorization is as valid as the original.

2 Physician information – to be completed by attending physician

Date patient first consulted you for ALS and Motor Neuron Disease (dd-mm-yyyy)	Date patient first consulted another physician for ALS and Motor Neuron Disease (dd-mm-yyyy)	
Date patient first suffered symptoms of ALS and Motor Neuron Disease (dd-mm-yyyy)	Date the diagnosis was confirmed (dd-mm-yyyy)	Date patient was informed of their condition (dd-mm-yyyy)

Confirm your diagnosis for this patient (primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, pseudo bulbar palsy or ALS).

Indicate what diagnostic test was used to establish the diagnosis. **Do not tell us about genetic testing or genetic testing results.**

2 **Physician information –** to be completed by attending physician (continued)

Provide the names and addresses of other physicians consulted or hospitals attended by patient for this or any other related condition. Also include the consultation reports or test results.

Physician/hospital name	Address

Are you aware if your patient's father, mother, brothers or sisters have **ever** suffered from ALS or neurological disorders or any other related condition? ☐ Yes ☐ No If '**yes**', provide details below.

Relationship	Name of condition	Year diagnosed	Age at diagnosis

Has the patient previously suffered from any related illness? ☐ Yes ☐ No If '**yes**', provide details.

Does your patient smoke? ☐ Yes ☐ No If '**no**', has your patient **ever** smoked? ☐ Yes ☐ No

If '**yes**', provide details of smoking history.

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

Ensure you provide us with copies of any specialist reports, including copies of any tests, readings, or similar evidence in support of your patient's claim. Do not tell us about genetic testing or genetic testing results.

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3 Physician's authorization and signature

Any information provided by you to Sun Life Financial about this claim may be disclosed to the patient and/or those authorized by them to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

Physician's last name (please print)	First name		Speciality
Address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number
Date (dd-mm-yyyy)	Physician's signature X		

Please send the completed original form to:

Sun Life Assurance Company of Canada
227 King Street South, PO Box 1601 Stn Waterloo
Waterloo, ON N2J 4C5

You can fax this form to fax number 1-866-487-4745. If you do, please keep a copy for your future reference and ensure the original form is sent to the address above.

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