SSQ Financial Group

Values in the right place

CRITICAL ILLNESS
CLAIMANT'S STATEMENT

SSQ Insurance Company Inc., 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

INSTRUCTIONS
1. Fill out the claimant's statement and sign the authorizations.
2. Have the back filled out by the attending physician.
3. All costs incurred are at the claimant's expense.

POLICY N^{O}.

Identification of the Claimant

Surname and first name

Name at birth

Address

Province

Postal code

Sex: ☐ F ☐ M

Date of birth (Y Y Y Y M M D D)

Home phone

Work phone

Information Related to the Illness

Does this involve: ☐ a motor vehicle accident ☐ a work accident ☐ a fall ☐ an illness ☐ other:

Date of the accident, if applicable, or date of the start of illness: (Y Y Y Y M M D D)

Type of injury or illness:

Describe the circumstances of the accident, if applicable :

If an illness, on what date did the first symptoms appear: (Y Y Y Y M M D D)

Date of the first consultation: (Y Y Y Y M M D D)

Have you previously suffered from this illness before? ☐ No ☐ Yes If yes, specify the date: (Y Y Y Y M M D D)

Name and address of the physician that you consulted the first time for the critical illness

Name and address of the other physicians who have treated you for the critical illness

Name and address of your family physician for the last five (5) years

Have you stayed in a hospital or other health care facility? (Full name and address)

☐ No ☐ Yes If yes, which one?

Period in hospital

from: (Y Y Y Y M M D D) to: (Y Y Y Y M M D D)

Do you use tobacco products (cigarette, cigar, pipe, cigarillos) or in any other form? ☐ No ☐ Yes

Have you ever used tobacco products? ☐ No ☐ Yes If yes, on what date did you stop smoking? (Y Y Y Y M M D D)

I STATE THAT THE ANSWERS ABOVE ARE COMPLETE AND TRUTHFUL.
ALL COSTS INCURRED IN FILLING OUT THIS FORM ARE AT THE CLAIMANT'S EXPENSE.

X

Claimant's signature

Date (Y Y Y Y M M D D)

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CRITICAL ILLNESS
ATTENDING PHYSICIAN'S STATEMENT

SSQ Insurance Company Inc., 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

INSTRUCTIONS
1. Fill out the attending physician's statement and return it to the patient.
2. All costs incurred are at the patient's expense.

Patient's first name and surname

Diagnosis

Main diagnosis

Date of this diagnosis
Y Y Y Y M M D D

Is the patient's current state:

☐ Due to an illness *Please specify the illness:* _____

☐ Due to an accident *Please specify the type of accident:* ☐ work ☐ motor vehicle ☐ other: _____

☐ Work-related *Please explain:* _____

Considering your patient's current condition, is this a first ever diagnosis of cancer?

☐ No ☐ Yes If yes, specify:

Date of this diagnosis
Y Y Y Y M M D D

Type of cancer

If this is not a first ever diagnosis of cancer, specify:

Date of the previous diagnosis
Y Y Y Y M M D D

Previous type of cancer

Was the patient in hospital? ☐ No ☐ Yes

Date of admission to hospital Y Y Y Y M M D D

Date of discharge Y Y Y Y M M D D

Name of hospital center

City

What are the objective symptoms? **(Attach copies of results from recent x-ray, ecg and other tests and examinations)**

When did the symptoms appear for the first time, or when did the accident occur?
Y Y Y Y M M D D

Date of the first medical visit
Y Y Y Y M M D D

Did the patient suffer previously from this condition or a similar condition?
☐ No ☐ Yes

If yes, specify the date(s) of the previous episode(s)
Y Y Y Y M M D D Y Y Y Y M M D D Y Y Y Y M M D D

Has the patient previously, for the primary diagnosis, received medical treatment, consulted a physician, undergone examinations, made use of medication or been hospitalized?
☐ No ☐ Yes If yes, please specify:

Has the patient remained under your care since the onset of the illness or since the accident? ☐ No ☐ Yes

On what date was the patient referred to you?
Y Y Y Y M M D D

If the patient was referred to you by other physicians, indicate their names, addresses and phone numbers

Does the patient use tobacco products (cigarette, cigar, pipe, cigarillos) or in any other form? ☐ No ☐ Yes

Has the patient ever used tobacco products? ☐ No ☐ Yes If yes, when did the patient stop? Y Y Y Y M M D D

Comments and pertinent information

Name of the attending physician (block letters)

Licence N°

Are you related to the patient?
☐ No ☐ Yes If yes, please specify:

Address of the attending physician

Telephone

X

Signature of the attending physician

Y Y Y Y M M D D
Date