# Critical Illness Insurance – Physician's statement – Cancer

Sun Life Financial

| Policy number |
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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 | 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<br>X |
|---|---|

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

## 2 Physician information – to be completed by attending physician

| Does patient have a definite diagnosis of a cancer confirmed by a biopsy? ☐ Yes ☐ No If 'yes', include a copy of the pathology report. | Type of cancer | Stage/classification |
|---|---|---|
| Date patient first suffered symptoms (dd-mm-yyyy) | Date patient first became aware of their condition (dd-mm-yyyy) | |
| Date patient first consulted you for their condition (dd-mm-yyyy) | Date patient first consulted a physician for their condition (dd-mm-yyyy) | |

Has patient had any prior history of cancer, malignancy, pre-malignancy or any similar condition? ☐ Yes ☐ No

If 'yes', provide dates of consultations and resulting diagnosis.

| Consultation date (dd-mm-yyyy) | Diagnosis |
|---|---|
| Consultation date (dd-mm-yyyy) | Diagnosis |

Provide the names and addresses of other physicians consulted or hospitals attended by your patient for this or any other related condition.

| Physician/hospital name | Address |
|---|---|
| | |
| | |

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

Have any other investigations, tests or procedures been performed? ☐ Yes ☐ No If 'yes', provide details.

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

| Relationship | Name of condition | Year diagnosed | Age at diagnosis |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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 or hospital reports, including copies of any pathology reports, together with any other tests, readings, or similar evidence in support of your patient's claim. Do not tell us about genetic testing or genetic testing results.**

## 3 Physician 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) | | | Suite |
| City | Province | Postal code | Telephone number |
| Date (dd-mm-yyyy) | Physician's signature<br>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.*