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CRITICAL ILLNESS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S FIRST NAME:	PATIENT'S LAST NAME:	DATE OF BIRTH:
WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILAR CONDITION? ☐ NO ☐ YES, WHEN?	DIAGNOSIS (INCLUDING COMPLICATIONS)

CANCER/ CARCINOMA IN SITU

DATE OF DIAGNOSIS (THE DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER OR CARCINOMA IN SITU WERE DIAGNOSED)	WAS THE CANCER/CARCINOMA IN SITU ☐ DIAGNOZED PATHOLOGICALLY ☐ CLINICALLY DIAGNOSED

IF THE CANCER/CARCINOMA IN SITU WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER/CARCINOMA IN SITU WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.

MYOCARDIAL INFARCTION (HEART ATTACK)

DOES THE PATIENT'S CONDITION MEET ALL OF THE FOLLOWING CRITERIA:

☐ Yes ☐ No ARE NEW AND SERIAL ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH MYOCARDIAL INFARCTION? ATTACH A COPY OF THE EKGs AND REPORTS.

☐ Yes ☐ No WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHYSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT

☐ Yes ☐ No DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ATTACH COPIES OF ANY APPLICABLE REPORTS.

☐ Yes ☐ No DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION?

DATE OF DIAGNOSIS: (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION)

CORONARY ARTERY BYPASS SURGERY

☐ Yes ☐ No DID THE PATIENT UNDERGO OPEN HEART SURGERY TO CORRECT NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH BYPASS GRAFTS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.

WHAT CONDITION CAUSED THE NEED FOR CORONARY ARTERY BYPASS SURGERY?	DATE THE PATIENT WAS FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

MAJOR ORGAN TRANSPLANT

☐ Yes ☐ No DID THE PATIENT UNDERGO SURGERY TO RECEIVE A HUMAN HEART, LIVER, LUNG, KIDNEY, PANCREAS, OR BONE MARROW? IF SO, ATTACH COPY OF THE OPERATIVE REPORT.

DATE THE PATIENT WAS FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

STROKE

☐ Yes ☐ No DID THE PATIENT HAVE A STROKE, MEANING APOPLEXY, SECONDARY TO RUPTURE OR ACUTE OCCLUSION OF A CEREBRAL ARTERY? STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERTERBROBASILAR ISCHEMIA, HEAD INJURY, OR CHRONIC CEREBROVASCULAR INSUFFICIENCY.

DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES?

RENAL FAILURE

☐ Yes ☐ No DOES THE PATIENT HAVE END STAGE RENAL FAILURE PRESENTING AS CHRONIC, IRREVERSIBLE FAILURE TO FUNCTION OF BOTH KIDNEYS?

☐ Yes ☐ No DOES THE PATIENT'S KIDNEY FAILURE NECESSITATE REGULAR RENAL DIALYSIS, HEMO-DIALYSIS OR PERITONEAL DIALYSIS (AT LEAST WEEKLY) OR WHICH RESULTS IN KIDNEY TRANSPLANTATION?

DATE OF DIAGNOSIS (THE DATE A DOCTOR OR PHYSICIAN RECOMMENDS THAT THE PATIENT BEGIN RENAL DIALYSIS.)

WHAT IS THE CAUSE FOR THE PATIENT'S RENAL DISEASE?

DATE THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

ATTENDING PHYSICIAN'S STATEMENT (continued)

PATIENT'S FIRST NAME:	PATIENT'S LAST NAME:	DATE OF BIRTH:

Is the patient unable to perform job duties? ☐ **No** ☐ **Yes** **If yes, please provide dates:**

What specific job duties is patient unable to perform?

Restrictions and Limitations: (Please quantify in hours, weight, etc.)

If retired or unemployed which activities of daily living (ADLs) is patient unable to perform?

Is the patient:

☐ Ambulatory

☐ Bed Confined

☐ House Confined

Was the patient hospitalized or confined to a skilled nursing facility? ☐ No ☐ Yes

If yes, Hospital Address:

Date Admitted:	**Date Discharged:**

Date you expect patient to resume partial duties?	**Date you expect patient to resume full duties?**

If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities?

Was the patient treated by any other physician's for this condition? ☐ No ☐ Yes

If yes, provide names and addresses of other treating physicians:

Remember, it is unlawful to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Check to be sure that all information is correct before signing. Please refer to page 3 for notice specific to your state

I hereby certify that the above described information is based upon reasonable medical probability and is true and correct to the best of my knowledge and belief.

ATTENDING PHYSICIAN'S SIGNATURE

I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

Name (Attending Physician) Please Print:	Degree:	Telephone Number:	
Address:	City:	State:	Zip code:
Signature:	Date:	Medical Id#:	