NATIONAL BANK INSURANCE

CLAIM REQUEST
Critical illness insurance
Heart attack (myocardial, infarction)
Declaration by Attending Physician

IDENTIFICATION OF INSURED

Loan/Policy No. _____ Transit _____

Surname at birth _____ Date of birth (YYYY MM DD) _____

First name _____ ☐ M ☐ F Sex

DECLARATION OF ATTENDING PHYSICIAN

1. a) Date of first consultation: _____ Date (YYYY MM DD)

   b) How long has this patient been in your care? _____

2. a) Has a myocardial infarction been diagnosed? ☐ Yes ☐ No

   b) Date of diagnosis: _____ Date (YYYY MM DD)

   c) Who made this diagnosis? _____

   d) Please indicate the name and address of any other physician consulted by the patient or the name and address of any hospital where the patient was treated for this hearth attack.

Name of physician or hospital	**Address** (No., Street, City, Province, Postal code)	**From** (YYYY MM DD)	**To** (YYYY MM DD)

3. Please provide a copy of the tests undergone by the patient in relation to the myocardial infarction.

   a) Changes to the **ECG** indicating a heart attack or copies of tracings if available:

   _____

   _____

   _____

   b) Levels of cardiac enzymes, including CPK – MB and the percentage of total CPK at the time of diagnosis:

   _____

   _____

   _____

4. Were other examinations carried out? Please indicate the dates and provide relevant information or reports.

   _____

   _____

   _____

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5. When did the patient suffer a heart attack or first show symptoms of having had a heart attack?

Date (YYYY MM DD)

Provide details and describe symptoms.

6. Please describe any predisposing condition or risk factor associated with the patient's heart attack, and include dates.

7. Does the patient have a family history of heart disease, stroke, cancer or diabetes ? Please provide details.

8. Please provide details of the patient's use of tobacco, marijuana, e-cigarettes and nicotine substitutes, including the quantity consumed daily, as well as the date when he stopped using tobacco.

9. Please include any other relevant information that could be useful in assessing the patient's claim request.

Please attach copies of any report prepared by a specialist or hospital for examination by our medical expert.

SIGNATURE OF THE ATTENDING PHYSICIAN

Name and address (in block letters):

Specialty:

Telephone No.:

Signature

Date (YYYY MM DD)

The patient is responsible for completing this form and assuming any applicable costs.