NATIONAL BANK INSURANCE

Insurer: National Bank Life Insurance Company

CLAIM REQUEST
ACCIDENTAL DISMEMBERMENT

Declaration of attending physician

LOAN OR CREDIT CARD INFORMATION

Transit No.

	Loan or card No.		Loan or card No.	
☐ Loan				
☐ Mortgage loan				
☐ MasterCard credit card		→ The claim concerns		→ The claim concerns
		☐ Cardholder		☐ Cardholder
		☐ Insured spouse		☐ Insured spouse

IDENTIFICATION OF INSURED

Last name (maiden name if applicable)

First name

Sex ☐ M ☐ F

DECLARATION OF ATTENDING PHYSICIAN

The purpose of this statement is to help us establish the degree of disability. Would you therefore please provide sufficient details regarding the history of the illness, your observations, your diagnoses, treatment prescribed and results obtained.

1. Date of birth Y M D

2. Diagnosis (including complications)

a) Date of first visit Y M D Date of last visit Y M D

b) Frequency of visits _____

c) Subjective symptoms _____

d) Objective symptoms (recent results of X-rays, ECG, laboratory tests and other tests)

e) As of what date do you consider this patient to have been totally disabled? Y M D

Date of accident that caused the loss in question Y M D

f) Was this accident the sole reason for amputation? ☐ yes ☐ no

If no, what illness or condition could have been a contributing factor?

3. Location of amputation

a) Indicate exact location

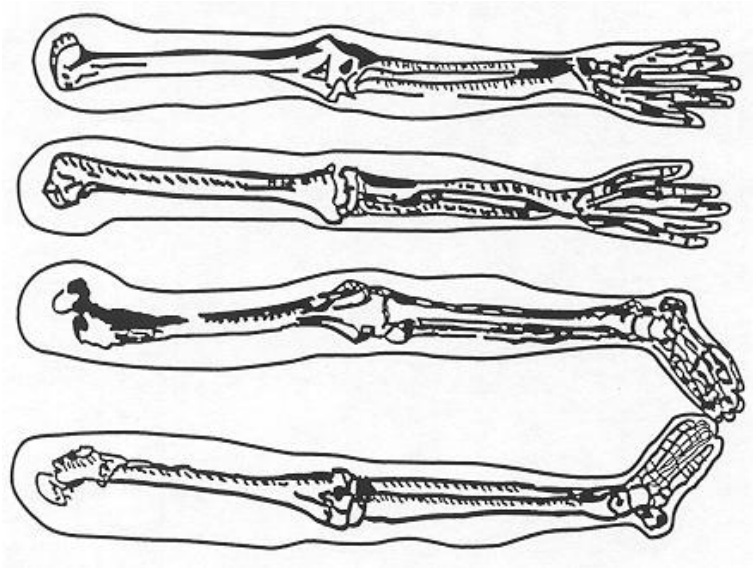
b) Date of amputation

Right arm — Y M D

Left arm — Y M D

Right leg — Y M D

Left leg — Y M D



4. Please provide the names and addresses of physicians who treated the patient for a contributing cause:

_____

_____

_____

5. Was the patient referred to other specialists? ☐ yes ☐ no

If yes, please provide the name and address of any other physician who followed this patient:

_____

_____

_____

6. Has your patient been treated for this problem before? ☐ yes ☐ no

If yes, when? Y M D

7. Give dates of hospitalization, if applicable: Date admitted Y M D Date released Y M D

8. Specify the type of surgery, if applicable:

_____

_____

_____

9. After release from hospital, when will the patient be able to carry out certain activities outside the home, such as visiting, running errands, etc.?

_____

_____

_____

_____

DEGREE OF DISABILITY

	HIS/HER OCCUPATION?	ANOTHER OCCUPATION?
Is the patient completely incapable of carrying out the tasks of:	☐ yes ☐ no	☐ yes ☐ no
If no, when will he/she be able to return to work?	Y M D	Y M D
If yes, when will he/she be able to return to work?	Y M D	Y M D
	☐ never	☐ never

If the date is undetermined, approximately how many more weeks or months will be necessary before returning to work?

_____ weeks _____ months

Would a gradual return to work be a possibility? ☐ yes ☐ no

If yes, explain the necessary procedure. If no, indicate why not.

_____

_____

_____

_____

SIGNATURE OF PHYSICIAN

Name of physician (please print) _____

Specialization _____

Address (No., street, city, province) _____ Code postal

Telephone number ( )

Signature of physician _____ Date Y M D

The patient is responsible for having his/her physician complete this form and paying any related charges.

This declaration may be mailed directly to the insurer or returned to the patient, as the physician chooses.