

CRITICAL ILLNESS CLAIM FORM

(Page 1 of 2)

				ATTENDING PHYSIC	IANO SIAI					
'ATIENT'S	FIRSTN	IAME:		PATIENT'S LAST NAME:		DATE OF BIRTH:				
VHEN DID SIGNS AND/OR YMPTOMS FIRST APPEAR?			HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILAR CONDITION? NO YES, WHEN?			DIAGNOSIS (INCLUDING COMPLICATIONS)				
				CANCER/ CARCI	NOMA IN SI	TU				
				OGICAL SPECIMEN(S) WERE OBTA	AINED ON	WAS THE CANCER/CARCINOMA IN SITU				
VHICH CAI	NCER OF	R CARCINOMA IN S	SITU WER	E DIAGNOSED)		DIAGNOZED PATHOLOGICALLY CLINICALLY DIAGNOSED				
SITU WAS	CLINICAL		PLEASE P	ROVIDETHE REASON(S) THAT PA		THE PATHOLOGY REPORT. IF THE CANCER/CARCINOMA IN IAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL				
				MYOCARDIAL INFARCTI	ON (HEART	ATTACK)				
OES THE	БУШЕ	NTS CONDITION	JMEET	ALL OF THE FOLLOWING CRI	TEDIA:					
Yes	No		SERIAL E	ELECTROCARDIOGRAPHIC (EKG) F		ISTENT WITH MYOCARDIAL INFARCTION? ATTACH A				
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 PATIE	DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION?							
		NO (THE DATE T	IE DATIE	UTAGE ALL OF THE ABOVE OBJECT		ALPRIAL INITARIOTION				
				NT MET ALL OF THE ABOVE CRITE		,				
Yes WHAT CON	No IDITION (ARTERIES WITH	BYPASS	CORONARY ARTERY	BYPASS SU CORRECT NARR OF THE OPER	JRGERY OWING OR BLOCKAGE OF ONE OR MORE CORONARY				
		ARTERIES WITH	BYPASS	CORONARY ARTERY RGO OPEN HEART SURGERY TO C S GRAFTS? IF SO, ATTACH A COPY	BYPASS SUCCEPTION OF THE OPERATERY?	JRGERY OWING OR BLOCKAGE OF ONE OR MORE CORONARY ATIVE REPORT.				
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		IAN'S STATEMENT (co	ontinued)				
PATIENT'S FIRSTNAME:	PATIENT'S LAST N	IAME:	DATE OF BIRTH:				
Is the patient unable to perform job duties? No	Yes If y	es, please provide dates:	•				
What specific job duties is patient unable to perf	form?						
Restrictions and Limitations: (Please quantify in ho	ours, weight, etc.)						
If retired or unemployed which activities of daily liv	ing (ADLs) is patie	nt unable to perform?					
Is the patient:	Was the national	beenitelized or confined to a abili	ad nursing facility 2 No.	Vac			
Ambulatory	was the patient i	Was the patient hospitalized or confined to a skilled nursing facility? No Yes					
Bed Confined	Confined If yes, Hospital Address:						
House Confined	Date Admitted:		Date Discharged:				
Date you expect patient to resume <u>partial duties</u> ?		Date you expect patient to resume <u>full duties?</u>					
If patient is unemployed or retired, on what date wo necessary activities?	uld you expect a p	erson of like age, gender and	good health to resume his/	her normal and			
Was the patient treated by any other physician's for this	s condition? No	Yes					
If yes, provide names and addresses of other treating	ng physicians:						
Remember, it is unlawful to fill out this form with facts y information is correct before signing. Please refer to pa			relevant and important. Chec	k to be sure that all			
I hereby certify that the above described information in the land of the land	,	•	bility and is true and corre	ect to the best of my			
	ENDING PH	YSICIAN'S SIGNAT	URE				
I hereby certify that the above described inform knowledge and belief.	ation is based up	on reas onable medical proba	ability, and is true and cor	rect to the best of my			
Name (Attending Physician) Please Print:	Degree: Tel		ephone Number:				
Address:	City:	Sta	te:	Zip code:			
Signature:	Date:	Med	dical Id#:	1			