Claim
Critical illness insurance
Stroke

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St
PO Box 1500, Quebec QC G1K 8X9
Fax: 418 643-7323 or 1 855 669-8830
Email: collectif_deces@lacapitale.com

Need help completing this form?
Call us at 418 644-4200 or 1 800 463-4856.
You can download a printable version of this form from La Capitale's website at
lacapitale.com/forms

IMPORTANT NOTE: When disclosing medical and health information, the results of any genetic test should not be included.

Group No.	Employer No.	Identification No.

1. INFORMATION ABOUT THE PARTICIPANT

Last name	First name	Gender ☐ M ☐ F

No. and street	City

Province	Postal code	Home tel.

2. INFORMATION ABOUT THE CLAIMANT

Last name	First name	Gender ☐ M ☐ F

Date of birth (Year / Month / Day)	Last day worked (Year / Month / Day)	This claim concerns the: ☐ Participant ☐ Spouse ☐ Dependent child

Address, if different from that of the participant

No. and street	City

Province	Postal code	Home tel.

PLEASE NOTE THAT CLAIMANTS MUST HAVE THE ATTENDING PHYSICIAN'S STATEMENT ON THE REVERSE SIDE OF THIS FORM COMPLETED BY THEIR PHYSICIAN AND ARE RESPONSIBLE FOR ANY FEES CHARGED.

3. AUTHORIZATION

I authorize any physician, any other professional and any intervening party in the field of health and rehabilitation, as well as any public or private health and social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency that may receive such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding personal files or information, particularly medical records pertaining to myself, not including genetic test results, and any of my dependents, to provide to La Capitale Civil Service Insurer Inc. or its mandataries, any information held that may be required for the processing of my file.

This authorization is valid for the purposes of this contract and for any amendments, extensions or renewals. A photocopy of this authorization is considered as valid as the original.

If you have applied for Family coverage status, the authorization of your spouse and dependent children age 18 or over is also required.

X ______________________ Date: Year Month Day
Participant's signature or, if a minor, signature of legal guardian

X ______________________ Date: Year Month Day
Spouse's signature

X ______________________ Date: Year Month Day
Dependent's signature if age 18 or over

X ______________________ Date: Year Month Day
Dependent's signature if age 18 or over

4. ATTENDING PHYSICIAN'S STATEMENT (Please print)

4.1 When did the insured first become a patient of yours? Year Month Day

4.2 When did your patient's symptoms first occur? Year Month Day

4.3 What did they consist of? ______

4.4 What is the date of the first consultation with regard to this condition? Year Month Day

4.5 Has the patient experienced paralysis or other neurological deficits? ☐ No ☐ Yes

4.6 If so, what are the neurological sequelae? ______

4.7 Duration of paralysis or neurological deficit: Year Month Day to Year Month Day

4.8 Are the neurological sequelae temporary or permanent? ☐ Temporary ☐ Permanent

4.9 To your knowledge, have there been other consultations and/or hospital stays for the same symptoms, in the weeks or months leading up to this stroke? ☐ No ☐ Yes – If so, please specify:

4.10 Does your patient have any risk factors for stroke?

	Yes	No	Since when?	Medication
Hypertension	☐	☐	Year Month Day	
Tobacco use	☐	☐	Year Month Day	
Dyslipidemia	☐	☐	Year Month Day	
Diabetes	☐	☐	Year Month Day	

4.11 Please enter the name of any other physician whom the insured has consulted or any hospital where the insured has received treatment for this condition or a related one:

Please provide us with any other information that you believe would be pertinent to analyzing this claim. Please include copies of any specialist or hospital reports for use by our medical director.

Our contract requires that the diagnosis of a covered illness be made by a physician who is not a relative or a business associate of the insured. Are you a relative or a business associate of the insured? ☐ Yes ☐ No

Physician's signature

Date: Year Month Day

Physician's name (please print)

Licence No.

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Claim

Critical illness insurance
Cancer

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Province	Postal code	Home tel.

2. INFORMATION ABOUT THE CLAIMANT

Last name	First name	Gender ☐ M ☐ F

Date of birth (Year / Month / Day)	Last day worked (Year / Month / Day)	This claim concerns the: ☐ Participant ☐ Spouse ☐ Dependent(s)

Address, if different from that of the participant

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Province	Postal code	Home tel.

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X ______________________ Date: Year Month Day
Spouse's signature

X ______________________ Date: Year Month Day
Dependent's signature if age 18 or over

X ______________________ Date: Year Month Day
Dependent's signature if age 18 or over

4. ATTENDING PHYSICIAN'S STATEMENT (Please print)

4.1 When did your patient's symptoms first occur? Year Month Day

4.2 What did they consist of? ______

4.3 On what date did your patient first consult you for this condition? Year Month Day

4.4 When did the insured first become a patient of yours? Year Month Day

4.5 On what date was this cancer diagnosed? Year Month Day

4.6 On what date was the patient informed of the diagnosis? Year Month Day

4.7 By whom? ______

4.8 Please provide a copy of the pathology report and specify the following:

- Type of tumor
- Location of tumor
- Clinical stage T N M
- Histology and classification

4.9 Please enter the names and addresses of other physicians whom your patient consulted or hospitals where the patient was treated for this cancer:

Name	Address	Period

4.10 Has your patient previously suffered from cancer or from any health problem that might have contributed to this illness? ☐ No ☐ Yes
If so, please provide the dates and pertinent information:

4.11 Has your patient undergone an HIV screening test? ☐ Yes, on Year Month Day ☐ No ☐ Don't know
If so, what were the results? ______

4.12 Does the patient have a family history of cancer? ☐ No ☐ Yes
If so, please provide details in that regard: ______

Please include information on any other significant family history: ______

4.13 Please provide us with any other information that you believe would be pertinent to analyzing this claim:

Please provide copies of any specialist or hospital reports for use by our medical director.

Our contract requires that the diagnosis of a covered illness be made by a physician who is not a relative or a business associate of the insured.
Are you a relative or a business associate of the insured? ☐ Yes ☐ No

X ______ Date: Year Month Day
Physician's signature

Physician's name (please print) Licence No.

THE CLAIMANT IS RESPONSIBLE FOR ANY FEES CHARGED FOR THE COMPLETION OF THIS FORM.

P1032E (04-2020)

La Capitale

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Claim

Critical illness insurance
Heart attack (myocardial infarction)

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Participant's signature or, if a minor, signature of legal guardian

X ____________________ Year Month Day
Spouse's signature

X ____________________ Date: Year Month Day
Dependent's signature if age 18 or over

X ____________________ Year Month Day
Dependent's signature if age 18 or over

4. ATTENDING PHYSICIAN'S STATEMENT (Please print)

4.1 a) On what date did your patient first consult you for this condition? Year Month Day

b) When did the insured first become a patient of yours? Year Month Day

4. ATTENDING PHYSICIAN'S STATEMENT (cont.)

4.2 **a)** Was a diagnosis of myocardial infarction made? ☐ No ☐ Yes

b) If so, when was the diagnosis made? Year Month Day

c) By whom?

Please provide the names and addresses of other physicians who were consulted or hospitals to which the patient was admitted for this illness:

4.3 Please provide the following details pertaining to your patient's heart attack:

a) Description of chest pain:

b) Date of onset of symptoms: Year Month Day

c) Electrocardiographic changes at the time of the attack or copies of pertinent ECG tracings:

d) Details of changes in myocardial marker enzymes at the time of the attack:

4.4 Details of any other investigations (dates and reports):

Date: Year Month Day

Date: Year Month Day

4.5 When did your patient first experience symptoms or episodes of cardiovascular disease? (Details and dates)

Date: Year Month Day

Date: Year Month Day

4.6 Please describe and provide dates for any of the patient's risk factors for cardiovascular disease, including genetic predisposition:

4.7 Do you know if any of the patient's family members have suffered from this condition or a similar condition? ☐ No ☐ Yes – If so, please provide details:

4.8 Please provide details concerning tobacco use (number of cigarettes smoked per day or date on which the patient quit smoking):

4.9 Please provide us with any other information that you believe would be pertinent to analyzing this claim:

Please provide copies of any specialist or hospital reports for use by our medical director.

Our contract requires that the diagnosis of a covered illness be made by a physician who is not a relative or a business associate of the insured. Are you a relative or a business associate of the insured? ☐ Yes ☐ No

X

Physician's signature

Date: Year Month Day

Physician's name (please print)

Licence No.

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Claim

Critical illness insurance
Kidney failure

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X ______________________ Date: Year Month Day
Spouse's signature

X ______________________ Date: Year Month Day
Dependent's signature if age 18 or over

X ______________________ Date: Year Month Day
Dependent's signature if age 18 or over

4. ATTENDING PHYSICIAN'S STATEMENT (Please print)

4.1 **a)** On what date did your patient first consult you for this condition? Year | Month | Day

b) When did the insured first become a patient of yours? Year | Month | Day

4.2 When did your patient first exhibit symptoms, suffer from kidney disease or experience impaired renal function? Year | Month | Day

Please provide details in that regard: ____________________

4.3 **a)** Does your patient have end-stage irreversible failure of both kidneys?

b) What caused the kidney failure?

c) On what date did your patient begin dialysis? Year | Month | Day

d) Does your patient receive kidney dialysis on a regular basis? ☐ Yes ☐ No

e) Has the patient had or going to have a kidney transplant? ☐ Yes ☐ No

4.4 Please provide the results of pertinent laboratory investigations and examinations:

4.5 Please describe and provide dates for any of the patient's risk factors for kidney disease such as diabetes and hypertension, including genetic predisposition:

4.6 **a)** Does the patient have a family history of kidney disease? ☐ No ☐ Yes – Please provide details in that regard:

b) Please provide information regarding any other significant family history:

4.7 Please provide the names and addresses of other physicians whom your patient consulted with regard to this condition:

Name of physician or hospital	Address	From (year – month – day)	To (year – month – day)

4. ATTENDING PHYSICIAN'S STATEMENT (cont.)

4.8 Please provide information on your patient's smoking habits, including the number of cigarettes smoked per day and the date on which the patient smoked for the last time:

____

____

4.9 Please provide any other information that would be helpful in assessing your patient's claim:

____

____

Please provide copies of any specialist or hospital reports for use by our medical director.

Our contract requires that the diagnosis of a covered illness be made by a physician who is not a relative or a business associate of the insured. Are you a relative or a business associate of the insured? ☐ Yes ☐ No

X ______________________________ Date: Year Month Day

Physician's signature

______________________________ ______________________________

Physician's name Licence No.

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Claim

Critical illness insurance
Aortocoronary bypass surgery

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X
Participant's signature or, if a minor, signature of legal guardian — Date: Year Month Day

X
Spouse's signature — Date: Year Month Day

X
Dependent's signature if age 18 or over — Date: Year Month Day

X
Dependent's signature if age 18 or over — Date: Year Month Day

LaCapitale

Claim
Critical illness insurance
Aortocoronary bypass surgery

4. ATTENDING PHYSICIAN'S STATEMENT (Please print)

4.1 When did your patient first exhibit symptoms or suffer from cardiovascular disease? Year Month Day

Please provide details in that regard: ______________________

4.2 On what date did your patient first consult you for the symptoms experienced? Year Month Day

4.3 When did this person first become a patient of yours? Year Month Day

4.4 Please provide the observations concerning the preoperative angiography or a copy of the report: ______________________

4.5 Please provide a copy of the surgical report, if any, or provide information on the aortocoronary bypass surgery:

Date of surgery: Year Month Day

Which arteries were involved? ______________________

4.6 Please indicate the names and addresses of the hospitals where the insured was treated and of the physicians and surgeons consulted:

Name	Address	Period

4.7 Please describe and provide dates for any of the patient's risk factors for cardiovascular disease, including genetic predisposition:

4.8 Please include any other information considered relevant and enclose copies of any specialist or hospital reports.

Physician's signature

Date: Year Month Day

Physician's name (please print)

Licence No.

P1035E (01-2020)

La Capitale

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Claim

Critical illness insurance
Multiple sclerosis

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Date of birth	Last day worked	This claim concerns the: ☐ Participant ☐ Spouse ☐ Dependent child
Year Month Day	Year Month Day	

Address, if different from that of the participant

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X ______________________________ Date: Year Month Day
Spouse's signature

X ______________________________ Date: Year Month Day
Dependent's signature if age 18 or over

X ______________________________ Date: Year Month Day
Dependent's signature if age 18 or over

4. ATTENDING PHYSICIAN'S STATEMENT (Please print)

4.1 **a)** When did your patient first exhibit symptoms? Year Month Day

What did they consist of?

b) On what date did your patient first consult you with regard to this condition? Year Month Day

c) When did the insured first become a patient of yours? Year Month Day

4.2 Please provide an outline of the clinical course, and briefly describe the patient's neurological problems and symptoms, including the dates and durations of the flare-ups:

4.3 On what date was the diagnosis of possible multiple sclerosis first discussed with the patient? Year Month Day

4.4 Please provide:

a) A copy of the imaging report confirming the diagnosis

b) The names and addresses of other physicians whom your patient consulted or hospitals where your patient received attention with regard to this condition

Name of physician or hospital	Address	**From** (year – month – day)	**To** (year – month – day)

c) The name and address of the neurologist who confirmed the diagnosis

Neurologist's name	Address	**Telephone No.** including area code

4.5 Does the patient have a family history of multiple sclerosis? ☐ No ☐ Yes – Please provide details in that regard:

4.6 Does the patient have any other significant family history? ☐ No ☐ Yes –Please provide details in that regard:

4. ATTENDING PHYSICIAN'S STATEMENT (cont.)

4.7 Please provide information on your patient's smoking habits, including the number of cigarettes smoked per day and the date on which the patient smoked for the last time:

4.8 Please provide any other information that would be helpful in assessing your patient's claim:

Please provide copies of any specialist or hospital reports for use by our medical director.

Our contract requires that the diagnosis of a covered illness be made by a physician who is not a relative or a business associate of the insured. Are you a relative or a business associate of the insured? ☐ Yes ☐ No

X
Physician's signature

Date: Year Month Day

Physician's name (please print)

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