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INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

IA PACIFIC™

CRITICAL ILLNESS

Any charges for completing this form are the responsibility of the claimant.

CLAIMANT'S STATEMENT

For a refund of premiums following the death of the insured, please use form F55-21A.

Contract number

Agent _____ Agency _____ Code _____ S.U. _____

Insured's last name _____ First name _____ Date of birth Y M D

Address _____
No. Street Apt.

_____ Postal code
City Province

Telephone: Social Insurance Number

Nature of illness or surgery: _____

Date symptoms first appeared: _____

Description of intitial symptoms: _____

_____

Date of diagnosis established by a physician or date of surgery: _____

Date of first consultation: _____

Name of your family physician: _____

Address _____
No. Street Apt.

_____ Postal code
City Province

Names of physicians consulted (if you do not have the name, state the name of the clinic or hospital)	**Date**	**Address**	**Reasons**

Have you, or any member of your family, ever suffered from this condition? If so, complete the information below:

Relationship to the insured	**Nature of illness**	**Date**

Have you submitted a claim to another insurance company for this condition?

_____

Do you use tobacco product(s)? If so, since when? _____

Have you ever used tobacco product(s)? ❑ Yes ❑ No If so, when did you stop? _____

I declare that the information provided in this claim is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

Signed at _____ Date _____

_____ Witness

_____ Insured

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ATTENDING PHYSICIAN'S STATEMENT

Patient's name: _____ Date of birth Y M D

Nature of illness: _____

Has the patient ever suffered from a similar condition? _____

Date the symptoms first appeared: _____

Description of symptoms:

_____

_____

_____

Date of first consultation: _____

Date of diagnosis: _____

Name of physicians who referred the patient to your attention or to whom you have referred the patient:

Name	**Clinic or Hospital**
_____	_____
_____	_____

This form will be used to open a file in order to determine if the insured is entitled to a critical illness benefit. The covered illnesses are indicated in the policy. If the conditions are met, **Industrial Alliance Insurance and Financial Services Inc.** or its affiliate **Industrial Alliance Pacific Insurance and Financial Services Inc.** will contact you to obtain additional information related to the illness using the authorization form signed by the client. If you require a specific form for the authorization, please attach it to this form.

Name of attending physician (capital letters): _____

Address _____

No. Street Apt.

_____ Postal code

City Province

Telephone:

Signed at _____ Date _____

_____

Physician's Signature