CRITICAL ILLNESS

INSURANCE AND FINANCIAL SERVICES INC. www.inalco.com

The claimant is responsible for any fees to complete this form

Life and Health Claims
1080 Grande Allée West
PO Box 1907, Station Terminus
Quebec City, QC G1K 7M3

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? ______

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, the Company 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