AIG Insurance Company of Canada
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PHYSICIAN'S STATEMENT
Loss of Sight

Policyholder: Province of New Brunswick

1. Full name of Insured: _____ Date of Birth (M/D/Y): _____

2. Full description of injury sustained: _____
   _____

3. Date of First Attendance (M/D/Y): _____ Date of Actual Loss (M/D/Y): _____

   a) Please outline all treatment provided with regards to condition and attach a copy of all ophthalmology test results and consultation reports: _____
   _____
   _____

   b) Please outline any scheduled surgery or corrective treatment and dates for such treatment:
   _____
   _____

   c) Percentage of Loss of Eye Sight: _____% ☐ Left Eye ☐ Right Eye Current Visual Acuity: _____

4. Is claim the direct result of an accident? ☐ Yes ☐ No

5. Did any disease or previous injury contribute to loss? ☐ Yes ☐ No If yes, describe: _____
   _____

6. Is loss complete and irrecoverable? ☐ Yes ☐ No

   a) Was claimant hospitalized? ☐ Yes ☐ No If yes, give hospital name, address and date admitted:
   _____
   _____

7. Name and address of other physicians or surgeons, if any, who attended claimant.
   _____
   _____

8. Are you related to or in a business relationship with this patient? ☐ Yes ☐ No

These statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician: _____
Address: _____
Signature of Attending Physician: _____ Date (M/D/Y): _____
Phone Number: _____ Fax Number: _____

The submission of forms shall not be an admission of liability by the Company.