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PHYSICIAN'S STATEMENT
Paralysis

Policyholder: Province of New Brunswick

Full name of Insured: _____Date of Birth (M/D/Y): _____

In order for a claim for Paralysis to be considered under this insurance policy, the policy definition must be satisfied.

As used in the policy the term Paralysis applies to Quadriplegia, Paraplegia, or Hemiplegia and means the complete and irreversible paralysis of such limbs. "Quadriplegia" means the complete and irreversible paralysis of both upper and lower limbs. "Paraplegia" means the complete and irreversible paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body. "Limb" means entire arm or entire leg.

Please print or type all your answers.

1. a) Please provide a description of the injury sustained leading up to patient's paralysis:
   _____
   _____
   b) When did the patient first consult you for this condition (M/D/Y)? _____
   c) On what date was the diagnosis made (M/D/Y)? _____
   d) By whom was the diagnosis made? _____

2. Please give the names and addresses of all physicians consulted or hospitals attended by your patient for his/her condition:

Name of Physicians or Hospital	Address	Date From: M/D/Y	Date To: M/D/Y

   Please give the following details pertaining to the insured's paralysis:
   a) What limbs are affected? _____
   _____
   b) Full details of loss of function: _____
   _____
   _____
   c) Is the paralysis total and irrecoverable and determined to be permanent? ☐ Yes ☐ No
   d) Are there any other underlying medical conditions? ☐ Yes ☐ No
   e) What is the prognosis? _____

3. Would there be any treatment that might improve this condition? If yes, please advise: _____
   _____
   _____

4. Please give below any other information that would be helpful in the assessment of your patient's claim.

_____

_____

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.