AIG Insurance Company of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

PHYSICIAN'S STATEMENT
Critical Care – Heart Attack

Policyholder: Province of New Brunswick

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

In order for a claim for Heart Attack to be considered under this Critical Care insurance policy, the policy definition must be satisfied.

As used in the policy the term **Heart Attack** means the diagnosis of the death of a portion of the heart muscle, as a result of inadequate blood supply as evidenced by new electro-cardiographic (ECG) changes indicative of a myocardial infarction having occurred and including the elevation of cardiac enzymes. An incidental finding of ECG changes suggesting a prior myocardial infarction, in the absence of a corroborating event is not covered and does not consitute a "heart attack" for the purposes of this coverage.

Please print or type all your answers.

1. a) On what date did your patient first consult you for this condition (M/D/Y)? _____
   b) How long has this person been your patient? _____

2. a) Was a diagnosis of myocardial infraction made? ☐ Yes ☐ No
   b) On what date was the diagnosis made (M/D/Y)? _____
   c) By whom was the diagnosis made? _____

   Please give the names and address of physicians consulted or hospitals attended by your patient for this heart attack: _____
   _____
   _____

3. Please give the following details pertaining to the insured's myocardial infarction:
   a) Description and date of onset of chest pain (MM/DD/YY): _____
   _____
   _____
   b) ECG changes in detail at time of event or provide copies of tracings, if available:
   _____
   _____
   c) Cardiac enzymes levels, including CPK - MB fraction and percentage of total CPK at time of diagnosis:
   _____
   _____

4. What other investigations have been performed? Please give dates and details, or reports:
   _____
   _____

5. On what date did your patient first have symptoms or episodes of cardiovascular disease (M/D/Y)?

   _____

   Please give details: _____

   _____

   _____

6. Please describe including dates, any predisposing disorders or risk factors your patient had for cardiovascular disease: _____

   _____

   _____

7. Is there a family history of cardiovascular disease or cerebrovascular disease? ☐ Yes ☐ No

   Please give details: _____

   _____

   _____

8. Please provide details of patient's tobacco use including amount per day and date last used:

   _____

   _____

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

   _____

   _____

   _____

Please provide copies of any specialist or hospital reports for our Medical Director's review.

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.