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PHYSICIAN'S STATEMENT
Critical Care – Coronary Artery Bypass Surgery

Policyholder: Province of New Brunswick

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

In order for a claim for Coronary Artery Bypass Surgery to be considered under this Critical Care insurance policy, the policy definition must be satisfied.

As used in the policy the term **Coronary Artery Bypass Surgery** means, heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. The surgery must be recommended by a consultant cardiologist licensed and practicing in Canada.

Procedures **NOT** covered by this definition include: Non-surgical techniques such as balloon angioplasty, laser embolectomy or other non-bypass techniques.

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. When did the patient first suffer symptoms or episodes of cardiovascular disease and what were they (M/D/Y)? _____
   Please give details: _____
   _____
   _____
3. By whom was the diagnosis made? _____
   Please give the names and addresses of other physicians consulted or hospitals attended by your patient:
   _____
   _____
   _____
4. Please give the following details pertaining to the insured's bypass surgery and if available please provided operative notes:
   a) Date of surgery (M/D/Y): _____
   b) Which arteries were bypassed? _____
   _____
   _____
5. Please describe including dates, any predisposing disorders or risk factors your patient had for cardiovascular disease: _____
   _____
   _____

6. Is there a family history of cardiovascular disease or cerebrovascular disease? ☐ Yes ☐ No
   Please give details: _____
   _____
   _____

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

8. 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.