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 – Stroke or CVA

Policyholder: Province of New Brunswick

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

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

As used in the policy, the term **Stroke or CVA** means: (1) a cerebrovascular incident (other than a Transient Ischemic Attack (TIAs) suffered by the Insured Employee while his or her insurance under the contract is in effect and caused by infarction of brain tissue, cerebral hemorrhage, thrombosis, or embolization from an extra-cranial source lasting more than twenty-four (24) hours; and (2) producing measurable neurological deficit persisting wholly and continuously for at least thirty (30) days following the occurrence of such incident.

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 Cerebrovascular Accident made? ☐ Yes ☐ No
   b) On what date did the CVA occur (M/D/Y)? _____
   c) Please describe the cause of the CVA. _____
   _____
   _____
   d) Please describe the residual neurological deficits. _____
   _____
   _____
   e) How long have the neurological deficits persisted? _____
   _____
   f) By whom was the diagnosis made? _____

Please provide a copy of the CT Scan or MRI if available.

3. On what date was the patient advised of the diagnosis (M/D/Y)? _____
   By whom? _____

4. a) Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this stroke or CVA: _____
   _____
   _____
   b) What other investigations have been performed? _____
   _____
   _____

5. On what date did your patient first have symptoms or episodes of cerebrovascular disease (M/D/Y)? _____
   Please give details: _____
   _____
   _____

6. Please describe including dates, any predisposing disorders or risk factors your patient had for cerebrovascular 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.