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PHYSICIAN'S STATEMENT
Critical Care – Life-Threatening Cancer

Policyholder: Province of New Brunswick

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

In order for a claim for life-threatening cancer to be considered under this Critical Care insurance policy, the policy definition must be satisfied.

"Life-Threatening Cancer" means a disease of the Insured Employee which is first manifested while the Insured Employee's insurance under this contract is in effect, which is characterized by the presence of a malignant tumour and by the uncontrolled growth and spread of malignant cells and the invasion of tissues. (Includes leukemia, Hodgkin's disease, lymphoma and invasive malignant melanoma as well as cancers for which chemotherapy or radiation treatments have been recommended.)

"Life-Threatening Cancer" does not include the following forms of cancer:

- Malignant melanoma to a depth of 0.75 mm or less;
- carcinoma in situ;
- basal cell carcinoma and squamous cell carcinoma of the skin that have not metastasized;
- early prostate cancer diagnosed as T1a or T1b;
- any tumour in the presence of any Human Immunodeficiency Virus (HIV);
- pre-malignant lesions, benign tumours or polyps;
- stage A colon cancer;
- stage 1 Hodgkin's disease (unless requiring chemotherapy and/or radiation treatments)

Please print or type all your answers.

1. a) On what date did your patient first have symptoms (M/D/Y)? ____________________
   What were they? ____________________
   b) On what date did your patient first consult you for this condition (M/D/Y)? ____________________
   c) How long has this person been your patient? ____________________

2. a) Please give the date the cancer was diagnosed (M/D/Y): ____________________
   b) On what date was the patient advised of the diagnosis (M/D/Y)? ____________________
   By whom? ____________________

3. Please provide a copy of the pathology report giving the following details:
   a) Type of tumor: ____________________
   b) Site of tumor: ____________________
   c) Histology and staging: ____________________
   ____

4. Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer: ____________________
   ____

5. a) Has your patient previously suffered from cancer or predisposing disorders? ☐ Yes ☐ No
   If so, please give dates and details: ______________________________

   b) Has your patient ever been tested for the Human Immunodeficiency Virus? ☐ Yes ☐ No
   Date (M/D/Y): ______________________________
   Results: ______________________________

6. Is there a Family history of Cancer? ☐ Yes ☐ No
   Please give details: ______________________________
   ____

7. Please give 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:
   ____
   ____

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.