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PHYSICIAN'S STATEMENT
Accidental Dismemberment

Policyholder: **Province of New Brunswick**

1. Full name of the Insured: ______________________ Date of Birth (M/D/Y): __________

2. a) Is condition direct result of an accident? ☐ Yes ☐ No
   b) Date of Accident (M/D/Y): ______________________
   When did patient first consult you for this condition (M/D/Y)? ______________
   c) Nature of Injury (describe complications if any): ______________________
   ____

3. Did the accidental injury result in:

Loss of Hand(s): ☐ Right ☐ Left Severance location (wrist joint): ☐ Above/Through ☐ Below

Loss of Finger(s):
Severance was Through/Above First Phalanx/Phalanges: ☐ Yes ☐ No

Fingers Affected	Thumb	Index	Middle	Ring	5th
Right hand					
Left hand					

Loss of Foot/Feet: ☐ Right ☐ Left Severance location (ankle joint): ☐ Above/Through ☐ Below

Loss of Toe(s):
Severance was Through/Above Both/Phalanges: ☐ Yes ☐ No

Toes Affected	1st	2nd	3rd	4th	5th
Right foot					
Left foot					

Loss of Arm(s): ☐ Right ☐ Left Severance location (elbow joint): ☐ Above/Through ☐ Below
Loss of Leg(s): ☐ Right ☐ Left Severance location (knee joint): ☐ Above/Through ☐ Below

4. Did any disease or previous injury contribute to loss? ☐ Yes ☐ No If yes, describe: __________
   ____

5. Was Claimant hospitalized? ☐ Yes ☐ No If yes, give Hospital Name and Address: __________
   ____

6. Names and Addresses of other Physicians or Surgeons, if any, who attended patient.
   ____
   ____

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.