AIG Insurance Company Of Canada
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Toronto, ON M5J 0A8
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PHYSICIAN'S STATEMENT
Loss of Speech

Policyholder: Province of New Brunswick

1. Full name of Insured:_____

2. Date of Birth: **M** _____ **D** _____ **Y** _____

3. Date of diagnosis: M _____ D _____ Y _____ First date of treatment: M _____D _____Y _____

4. Please provide a full description of the loss and treatment provided.

_____

_____

5. Please provide the etiology of the loss. _____

_____

_____

6. Please outline any scheduled surgery or corrective treatment and the dates for such treatment:

_____

7. Is loss complete and irrecoverable? ☐No, and if ☐Yes – Describe: _____

_____

8. Did any disease or previous injury contribute to loss? ☐No, and if ☐Yes – Describe below:

_____

_____

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

_____

_____

Please provide copies of all test results and consultation 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:_____

The furnishing of forms shall not be an admission of liability by the Company.