CRITICAL ILLNESS CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

Please return to: J&D Benefits Inc.
228-8901 Woodbine Avenue
Markham, ON L3R 9Y4
Telephone: 905-477-7088 1-800-218-7018

PATIENT INFORMATION – PLEASE NOTE THAT THE CLAIMANT IS RESPONSIBLE FOR ANY FEE CHARGED FOR THIS INFORMATION

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

IN ORDER TO FACILITATE THE ASSESSMENT OF THIS CLAIM, PLEASE ATTACH ALL HOSPITAL RECORDS, TEST RESULTS, CONSULT NOTES AND SPECIALIST REPORTS APPLICABLE TO THIS CONDITION.

First Name of Patient:	**Last Name of Patient:**	**Date of Birth:**
Diagnosis:		
How long has the insured been your patient?		
Date symptoms first appeared:	**Exact date of diagnosis:**	
Has the patient ever had the same or similar condition? ☐ **Yes** ☐ **No**		
If Yes, state when, if applicable, the duration and describe:		
Are there any predisposing risk factors related to the insured's diagnosis? ☐ **Yes** ☐ **No**		
Please describe:		
Has the patient undergone surgery/operation/procedure? ☐ **Yes** ☐ **No**		
Please provide details:		
Have you attached all hospital records, test results, consult notes and specialist reports applicable to this condition? ☐ **Yes** ☐ **No**		
Has the patient been hospitalized? ☐ **Yes** ☐ **No**	**Length of Stay: From: To:**	
Name of Hospital:		

Physician's Name (please print):	**Specialty:**
Address:	**City:**
Province:	**Postal Code:**
Phone #: ( )	**Fax #: ( )**
Email Address:	

Physician's Signature ______________________ Date ______________________