CRITICAL ILLNESS CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
O +1.416.594.2627 or +1.877.772.7797
claims.A_H@chubb.com

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 ______________________________