UV INSURANCE

GROUP INSURANCE

Confidential medical certificate

(To be completed by the treating physician)

Important: Fill out in block letters and answer each section as accurately as possible.

Section A – Collection, Use and Disclosure of Personal Information

This form allows UV Insurance to collect the insured person's health information for the purpose of starting or continuing a claim.

The personal information is used to:

- Identify the individual
- Establish and update information and the needs of the individual, as appropriate
- Comply with legal and regulatory requirements, including tax rules and the prevention, detection and enforcement of offences, cyber threats and fraud.

The information disclosed on this form will be forwarded to the UV Insurance staff in charge of processing the claim, as well as to any other person authorized by law.

Section B – Questionnaire

1. Certificate # _____ Group # _____ Division _____ Class _____
2. First name _____ Surname _____
3. Date of birth Y M D
4. Type of disease

☐ Cancer	☐ Benign brain tumour	☐ Paralysis	☐ Replacement of heart valves
☐ CVD	☐ Motor Neuron Disease	☐ Loss of Independence	☐ Coronary Artery Surgery
☐ Heart Attack	☐ Parkinson's Disease	☐ Speech Loss	☐ Aortic Surgery
☐ Alzheimer's Disease	☐ Loss of Deafness	☐ Multiple	☐ Sclerosis
☐ Kidney failure	☐ Burns	☐ HIV infection	☐ Blindness
☐ Coma	☐ Transplant or insufficient vital organ		☐ Other _____

5. Please indicate the degree and severity of illness _____
6. Please indicate the date of onset of the first symptoms for this disease Y M D
7. Please provide date of diagnosis Y M D
8. On what date was your patient notified of this diagnosis? Y M D
9. Are you the patient's regular treating physician? ☐ Yes ☐ No

   If **Yes**, please provide us with copies of your records, completed surveys (e.g., magnetic resonance, CT scan, lab results, electromyography, muscle biopsy, chromosome testing, etc.), diagnoses, referral reports and hospital summaries.

   If **No**, please provide the full name and address of the patient's regular treating physician and the names and addresses of all consultants, specialists or hospitals where the patient was treated or referred.

10. Are there notes on the family history of a related illness, or other related family history? ☐ Yes ☐ No

    If **Yes**, please specify:

Section B – Questionnaire (cont.)

11. Please write the original episode:

Date Y M D

Nature of the episode _____

Duration of acute symptoms _____

12. Please detail the patient's habits and medical history that could have increased the risk or contributed to the patient's condition.

13. Has an operation been required or is it expected? ☐ Yes ☐ No If **Yes**, please provide details:

Date Y M D Nature of the intervention _____

14. Please detail the patient's smoking habits, including according to your information, and if so, how many cigarettes were smoked in the past and how many are smoked today?

15. Date of return to normal activities and/or current physical and mental limitations? Y M D

16. If you have any other medical information that may assist us in assessing this application, please provide it to us.

Include a copy of the complete file you hold for the insured, including handwritten notes

Section C – Consent and Signature

Note that if any of the personal information provided herein is inaccurate, incomplete, or ambiguous, the insured may request that it be corrected by submitting a request to UV Insurance.

For more details, please visit our website and see our **Privacy Policy**.

As the attending physician, I declare that I am acting in accordance with privacy laws and regulations.

By signing at the bottom of this form, I confirm that the information provided is accurate.

Physician's signature

1. First name _____ Surname _____

2. Main address _____

City _____ Province _____ Country _____ Postal code _____

3. Specialty _____ **4.** Phone ___ ___ - ___ ext. _____

X _____ _____ Date Y M D

Signature Signatory's name in block letters

Physician's stamp

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