ATTENDING PHYSICIAN'S STATEMENT
ADVANCE PAYMENT REQUEST

Return completed form to: The Canada Life Assurance Company
Group Life Benefits 5W
60 Osborne Street N
Winnipeg MB R3C 1V3

OR

email: grouplifebenefits@canadalife.com
Fax: 204-946-8783

Physician Name	Telephone Number
Address	Email Address
Name of Insured	
Address: Street City Province Postal Code	Group Policy Number

The above named Insured has requested an advance payment of their Life Insurance proceeds due to a terminal illness. In order to provide consideration to the Insured's request, we require the following information:

Diagnosis: _____

If cancer, is it metastatic? ☐ Yes ☐ No What stage of cancer? _____

Is the Insured undergoing any treatment? ☐ Yes ☐ No

If yes, provide details: _____

Future Prognosis: _____

Life expectancy (survival rate): _____

Do you consider the Insured to be mentally competent/mentally able? ☐ Yes ☐ No

Please provide a description of the Insured's medical condition, including any complications, in the space provided below and attach **medical evidence to support the diagnosis**. (to be completed by a SPECIALIST physician if being followed by a specialist).

I certify the above information to be true and correct.

Date _____ Signature _____, M.D.