Loss of Independent Existence

Physician's Statement (Specialist only)

PLEASE PRINT

Name of patient: ______________________________ ______________________________ ______________

Surname First Name Date of Birth (mm/dd/yy)

Address: ____

Number & Street City Province Postal Code

Telephone (__________)________________________________

1. Please provide a brief outline of the medical history leading to your patient's loss of independent existence.

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2. When did your patient first consult you for the underlying medical condition that has led to this loss of independent existence (mm/dd/yy)?

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3. When did your patient first suffer symptoms of the medical condition that led to the loss of independent existence (mm/dd/yy)?

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4. Please provide the following:

   a) Details of exact loss of function including activities of Daily Living.

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   b) The underlying cause of this condition.

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   c) Details of cognitive function impairment, if any.

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5. Is the condition permanent without any likelihood of improvement? ______________________

6. Are there any treatments that could improve the function of this individual? ______________________

7. Please provide the names and addresses of other physicians consulted, or hospitals attended by your patient for this condition.

Name of Physician or Hospital	Address (Number, Street, City, Province, Postal Code)	Date From (Month, Day, Year)	Date To (Month, Day, Year)

8. Please provide results of all relevant investigations, including occupational therapy assessment and any cognitive testing results.

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

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Please provide copies of any specialist or hospital reports.

Name (Please print) | Degree

Street Address | City | Province | Postal Code

Area Code & Telephone Number | FAX number

Date (mm/dd/yy) | Signature ______________________ MD

This form is to be completed by a physician licensed in Canada whose practice is limited to the particular branch of medicine relating to the applicable critical illness. The INSURED is responsible for the completion of this form without expense to the Company.

PERSONAL INFORMATION CONSENT: The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Wawanesa Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy office.

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