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. Date of diagnosis: _____ mm/dd/yy

2. Diagnosis and concurrent conditions: _____

3. Describe subjective symptoms, include physical and mental limitations: _____

Provide copies of any x-rays, computed tomography scanning or magnetic resonance imaging, laboratory evidence as well as any other tests.

4. Date patient first consulted you for this condition (mm/dd/yy): _____

5. Are you the patient's usual medical attendant? ❒ Yes ❒ No

6. Is patient still under your care for this condition? ❒ Yes ❒ No

7. Has the patient ever had the same or similar condition? ❒ Yes ❒ No

   If yes, provide date and diagnosis (mm/dd/yy): _____

8. Is there permanent loss of voluntary movement to two or more limbs, including loss of power and sensation of those limbs, and for how long has this been present?

9 Did paralysis result from complications of surgery, spinal cord injury, multiple sclerosis, motor neurone disease or other condition (not including stroke)?

10. What treatment is planned? _____

THE WAWANESA LIFE INSURANCE COMPANY
236 Carlton St, Winnipeg, Manitoba R3C 1P5
Tel: 1-844-318-0411, #3 Fax: 1-855-496-3028
Email: WawanesaLife-claims@wawanesa.com
wawanesalife.com

11. Do you foresee any delay in completing planned treatment? ❒ Yes ❒ No

If Yes, describe: _____

12. Please give the name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition. Provide copies of any specialist or hospital reports for our Medical Director's review:

♦ Doctor's Name _____

Address _____
Street City Province Postal Code

♦ Doctor's Name _____

Address _____
Street City Province Postal Code

♦ Doctor's Name _____

Address _____
Street City Province Postal Code

13. If there is any further information which, in your opinion, will assist our Medical Director in assessing this claim, please give details:

_____

_____

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 officer.