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. a) On what date were you first consulted for the accident or condition causing severe burns and, at that time, how long had impairment been present?

   Date (mm/dd/yy) _____

2. a) Has your patient previously suffered from the condition specified above or any related condition? ❒ Yes ❒ No

   b) If YES, please state the dates and situations resulting in prior burns?

   _____

   _____

3. Please describe the circumstances leading to the occurrence of the burns.

   _____

   _____

4. What was the exact date of the incident resulting in severe burns? Date (month, day, year) _____

5. Please describe the extent of your patient's condition as follows:

   a) the percentage of the body surface covered by the burns

   _____

   b) which area of the body is affected by the burns (limbs, torso, etc.)

   _____

   c) the nature of the burns (first, second, and third degree burns)

   _____

6. Please draw a diagram showing the areas affected by the burns.

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

7. Please give details of any tests performed:

8. Please provide details of any surgery performed, including date, hospital, name of surgeon and site of graft:

Name of Surgeon and Hospital	**Address** (number, street, city, province, postal code)	**Date of Surgery** (mm/dd/yy)	**Site of Graft**

9. Are you aware of any liability claim involving a third party?

10. Please give the names and addresses of other physicians consulted by your patient for this condition:

Name of Physician	**Address** (number, street, city, province, postal code)	**Date from** (mm/dd/yy)	**Date to** (mm/dd/yy)

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

Please provide copies of any specialist or hospital records

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.