



Please return this completed form and supporting documents to:

Wawanesa Life - Claims  
236 Carlton St, Winnipeg, MB R3C 1P5  
For inquiries, please call: 1-844-318-0411, #3  
Email: WawanesaLife-claims@wawanesa.com  
Website: wawanesalife.com

# CRITICAL ILLNESS PHYSICIAN STATEMENT STROKE

## PATIENT AUTHORIZATION

Patient \_\_\_\_\_ Last Name First Name Group Plan # \_\_\_\_\_

I hereby authorize the release of medical and health information in my file to Wawanesa Life and its authorized agents for the purpose of assessing my Group Critical Illness claim and administering the benefit plan. This medical and health information includes but is not limited to, copies of all consultation reports, the clinical notes, test results and hospital records. I understand that I am responsible for any fees related to the completion of this form.

I acknowledge that the personal information is required by Wawanesa Life for the purpose stated above. I acknowledge that my consent enables Wawanesa Life to process my claim and refusing to consent may result in delay or denial of my claim.

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photo copy or electronic copy of this authorization shall be as valid as the original.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date (dd/mm/yyyy)

## CLINICAL INFORMATION

1. a) On what date did your patient first consult you for this condition? \_\_\_\_\_
- b) How long has the Plan Member been your patient? \_\_\_\_\_

2. a) Was a diagnosis of stroke made?  Yes  No
- b) On what date did the stroke occur? \_\_\_\_\_
- c) By whom was the diagnosis made? Provide names and specialty.
- d) On what date was the patient advised of the diagnosis? By whom?

3. Please provide the following details pertaining to the insured's stroke:
  - a) Please describe the stroke.
  - b) Please describe the residual neurological deficits.
  - c) How long have the neurological deficits persisted?

**CLINICAL  
 INFORMATION**

CONTINUED

4. a) What mobility aids (if any) have been prescribed?

b) What is current treatment regimen?

 5. When did your patient first suffer symptoms or episodes of cerebrovascular disease? What were they?  
 Please provide details and dates.

 6. Please describe, including dates, any predisposing conditions or risk factors which your patient has had  
 for cerebrovascular disease.

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

**Please provide copy of relevant clinical chart notes, test results,  
 consultation reports and hospital summaries.**

 Our plan requires that a Covered Condition be diagnosed by a physician who is not related to the Plan  
 Member. Are you related to the Plan Member?     Yes    No

 \_\_\_\_\_  
 Physician's Name (Please Print) & Speciality

 \_\_\_\_\_  
 Phone Number

 \_\_\_\_\_  
 Physician's Signature

 \_\_\_\_\_  
 Date

**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](mailto:privacy@wawanesa.com) or by calling 1-888-997-9965 and asking to speak to the Privacy Officer.

**WHEN COMPLETE**

**Please send report to: The Wawanesa Life Insurance Company, Group  
 Benefit Services, 236 Carlton St, Winnipeg, Manitoba R3C 1P5**