



6. Please describe, including dates, any predisposing disorders or risk factors your patient had for blindness.

7. Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related disorder.

8. 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 for our Medical Director's review. \*\*\***

Our contract requires that a covered illness be diagnosed by a physician who is not related to the insured. Are you related to the patient?  YES  NO

_____ Physician's Name (Please Print)	_____ Phone Number
_____ Physician's Signature	_____ Date

For Head Office Use Only

**WHEN COMPLETE**

**Please send report to: Medical Director, The Wawanesa Life Insurance Company, Group Operation  
400 – 200 Main Street, Winnipeg, Manitoba R3C 1A8**