



# CRITICAL ILLNESS BENEFIT CONFIDENTIAL PHYSICIAN'S STATEMENT CORONARY ARTERY BYPASS SURGERY

Group Operation  
400 – 200 Main Street, Winnipeg, MB R3C 1A8 1-800-665-7076

## EMPLOYER/EMPLOYEE IDENTIFICATION

Policy # \_\_\_\_\_ Employer Name \_\_\_\_\_ Claimant ID WLI \_\_\_\_\_  
Employee Name \_\_\_\_\_  
First Name \_\_\_\_\_ Last Name \_\_\_\_\_

**NOTE: This form should only be completed after the waiting period for your illness has been satisfied. Please refer to your policy contract for the appropriate waiting period.**

## CLAIM AND RELATED DETAILS

1. a) On what date did your patient first suffer symptoms or episodes of cardiovascular disease? What were they?  
\_\_\_\_\_  
b) On what date did the patient first consult you for these symptoms?  
\_\_\_\_\_  
c) How long has the insured been your patient?  
\_\_\_\_\_

2. Please provide the pre-operative angioplasty findings or a copy of the report.  
\_\_\_\_\_  
\_\_\_\_\_

3. Please provide a copy of the operative report if available or provide details of the bypass surgery:  
a) Date of Operation  
\_\_\_\_\_  
b) Which arteries were bypassed?  
\_\_\_\_\_  
c) Name and address of the hospital and the name of the operating surgeon.  
\_\_\_\_\_  
d) Name and address of the cardiologist recommending the bypass surgery.  
\_\_\_\_\_  
\_\_\_\_\_

For Head Office Use Only

4.	Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related condition.
5.	Please describe, including dates, any predisposing conditions or risk factors that your patient had for cardiovascular disease.
6.	Please provide any other information that would be helpful in the assessment of your patient's claim.
<b>*** Please provide copies of any specialist or hospital records for our Medical Director's review. ***</b>	
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? <input type="checkbox"/> YES <input type="checkbox"/> 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**