



CRITICAL ILLNESS BENEFIT
CONFIDENTIAL PHYSICIAN'S STATEMENT
MAJOR ORGAN TRANSPLANT

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. Please provide complete details of the disorder leading to your patient's transplant procedure.

2. a) On what date did your patient first suffer symptoms of this disorder? What were they?

b) On what date was the disorder first diagnosed?

c) On what date was the patient made aware of the diagnosis? By whom?

3. How long has this person been your patient?

4. How long had end stage disease been present?

5. Please give details of the transplant procedure performed, including the name and address of the hospital, the attending surgeon/physician and the date of the procedure.

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6.	Please describe, including dates, any predisposing disorders or risk factors the patient had for the underlying disorder.
7.	Please provide the names and addresses of other physicians attended by your patient for this or any related condition.
8.	Is there anything in your patient's habits or family history that increased the risk of the underlying disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO If 'YES', please provide details.
9.	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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
_____	_____
Physician's Name (Please Print)	Phone Number
_____	_____
Physician's Signature	Date
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WHEN COMPLETE

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