



CRITICAL ILLNESS BENEFIT CONFIDENTIAL PHYSICIAN'S STATEMENT STROKE

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 the patient first consult you for this condition?

b) How long has the insured 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? Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this stroke.

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 cause of stroke.

b) Please describe the residual neurological deficits.

c) How long have the neurological deficits persisted?

d) Please provide a copy of the CT Scan if available.

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4.	What other investigations have been performed? Please provide dates and details, or reports.
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 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**