

Attending Physician's Statement Accident Benefit Plan



Please return this completed form and supporting documents to:

The Wawanesa Life Insurance Company

Attn: Life Claims Department
236 Carlton Street, Winnipeg, Manitoba R3C 1P5
For inquiries, please call 1-844-318-0411
Fax: 1-855-496-3028 Email: wawanesalife-claims@wawanesa.com
wawanesalife.com

Plan Member/Employee Information

Plan Member/Employee Name: _____ Date of Birth (mm/dd/yyyy): _____

Telephone Number: _____ Cell Home

Name of Employer: _____

Group Plan Number: _____

Plan Member/Employee Authorization

I hereby authorize the release of medical and health information in my file to Wawanesa Life and/or its authorized agents for the purpose of assessing my claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but without it my claim cannot be assessed. I understand I am responsible for any fees related to the completion of this form.

Plan Member/Employee Signature

Date of Consent (mm/dd/yyyy)

Attending Physician's Statement (APS)

If accident/injury has not resulted in time off work, APS can be completed by a Paramedical treatment provider

What is your patient's diagnosis? _____

Did your patient sustain an injury as the result of an accident? Yes No

Did it result in an absence from work? Yes No If yes, first date of work absence (mm/dd/yyyy): _____

Date of first visit with the Plan Member (mm/dd/yyyy): _____

Was your patient hospitalized? Yes No If yes, date of admittance (mm/dd/yyyy): _____

Date of discharge (mm/dd/yyyy): _____ Remains hospitalized

Institution Name: _____

Procedure/treatment received in hospital: _____

History & Current Symptoms

Has the patient been treated for the same or similar condition in the past? Yes No If yes, date (mm/dd/yyyy): _____

Please provide details for the above (treatment provider, symptoms): _____

Current Condition

Please describe the patient's symptoms including history, severity and frequency:

Frequency of visits: Weekly Monthly Other: _____

Please explain if your patient's condition is directly or indirectly related to a Soft Tissue Injury (strain, sprain, contusion, hernia, or whiplash-type acute physical trauma)?

Does your patient have any restrictions or limitations from performing their job duties? Yes No

If yes, please specify their restrictions and/or limitations: _____

Treatment (Drug, Dosage, Physiotherapy, Rehab Program, Other)

Patient's current treatment plan: _____

Start date of Treatment (mm/dd/yyyy): _____ Cost of Treatment: _____

Expected duration (in weeks): _____ Patient's response to treatment to date: _____

Is your patient following the recommended treatment plan? _____

Do you have concerns about the patient's ability to manage their own affairs? _____

Please list any complications or additional conditions impacting your patient's level of function or the expected recovery period:

Prognosis: _____

Test Results/Investigations, Consultation Reports and Chart Notes

Did your patient have any investigative tests (x-ray, MRI, U/S)? Yes No

If yes, outline which tests were completed: _____

Please include all reports with the APS: Sent To follow

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician or Paramedical Health Provider Full Name (please print): _____

Certified Specialty: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number (include area code): _____ Fax Number: _____

Physician's Signature

Date Signed (mm/dd/yyyy)

Physician's Stamp: