Physician's Statement (Specialist only)

PLEASE PRINT

Name of patient: _____ _____
Surname First Name Date of Birth (mm/dd/yy)

Address: _____
Number & Street City Province Postal Code

Telephone ( ) _____

1. a) On what date were you first consulted for this condition? Date (month, day, year) _____

   And at that time, how long had symptoms been present? _____

   b) How long has this person been your patient? _____

2. Has your patient suffered any past episodes of coma or any related conditions? ❒ Yes ❒ No

   If YES, please provide details: _____

3. Please provide details of the underlying cause leading to your patient's coma.

4. a) How long was the patient in a state of coma? _____

   b) What support systems were required to maintain the survival of the patient?

   c) What tests were performed to determine the depth of the coma?

   d) Please provide the date and time of emergence from the coma and comment on the patient's physical and mental limitations at that time.

   Date (month, day, year) _____

THE WAWANESA LIFE INSURANCE COMPANY
400-200 Main Street, Winnipeg, Manitoba R3C 1A8
Tel: 1-844-318-0411, #3 Fax: 1-855-496-3028
Email: WawanesaLife-claims@wawanesa.com
wawanesalife.com

5. Please give the names and addresses of other physicians and hospitals attended by your patient for this condition:

Name of Physician or Hospital	**Address** (number, street, city, province, postal code)	**Date from** (month, day, year)	**Date to** **(month, day, year)**

6. 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.

Name (Please print) _____ Degree _____

Street Address _____ City _____ Province _____ Postal Code _____

Area Code & Telephone Number _____ FAX number _____

Date (mm/dd/yy) _____ Signature _____ MD

This form is to be completed by a physician licensed in Canada whose practice is limited to the particular branch of medicine relating to the applicable critical illness. The INSURED is responsible for the completion of this form without expense to the Company.

PERSONAL INFORMATION CONSENT: The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Wawanesa Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy officer.