

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.) Date of Diagnosis: _____ (mm/dd/yy)
B.) Indicate your diagnosis and cause of deafness. _____

C.) Is deafness permanent? Yes No

2. A.) Date when patient first suffered symptoms or became aware of any hearing loss or problem (mm/dd/yy): _____
B.) If loss of hearing was due to injury, provide details: _____

3. A.) Date patient first consulted you for any hearing problem (mm/dd/yy): _____

B.) How long has this person been your patient? _____

4. Is the patient still under your care for this condition? Yes No

5. A.) What is the auditory threshold in each ear? _____ Right _____ Left

B.) Give the date of the first audiogram that established this: _____ (mm/dd/yy)
Provide a copy of the audiogram if available.

C.) Provide name and address of otolaryngologist: _____

6. Describe including dates, any predisposing disorders or risk factors your patient had for hearing loss (mm/dd/yy): _____

7. Is there a family history of hearing loss? Yes No

If yes, provide details: _____

8. Is there any treatment that could improve your patient's hearing? Yes No

If yes, provide details: _____

9. Please give the name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition. Provide copies of any specialist or hospital reports for our Medical Director's review.

◆ Doctor's Name _____

Address _____
Street City Province Postal Code

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Address _____
Street City Province Postal Code

◆ Doctor's Name _____

Address _____
Street City Province Postal Code

10. If there is any further information which, in your opinion, will assist our Medical Director in assessing this claim, please give details:

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 office.r