



Dilated Cardiomyopathy 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. Please provide the diagnosis of your patient's condition?

2. What is the cause of your patient's condition?

3. When did your patient first experience symptoms (mm/dd/yy)? _____

4. When was your patient referred to you (mm/dd/yy)? _____

5. When did you see your patient for this condition (mm/dd/yy)? _____

6. When was the diagnosis made (mm/dd/yy)? _____

7. Please provide copies of all echocardiogram reports.

8. Is this impairment likely to be permanent? Yes No

9. Using the standard Bruce protocol if applicable, to what stage of a treadmill exercise test is your patient able to progress?

10. Please provide copy of any/all treadmill tests.

11. Is your patient's physical activity limited due to their condition? Yes No

If Yes, please provide details of the degree of physical limitation.

12. Please provide details of any other specialists that your patient has been seen by in connection with this condition.

13. Please provide details of treatment given/planned.

14. Has the patient previously suffered from the same or related condition? Yes No

If Yes, please provide full details including dates.

15. Are you aware of any misuse of alcohol or drugs in your patient's history? Yes No

16. Have any of the patients family members suffered from cardiovascular disease? Yes No

If Yes, please state the relationship to the patient, the condition and the age of diagnosis.

Name (Please print)

Degree

Street Address

City

Province

Postal Code

Area Code & Telephone Number

FAX number

M
D

Date (mm/dd/yy)

Signature

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.