Loss of Limbs

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 a brief outline of the medical history leading to your patient's loss of limbs.

_____

_____

_____

2. When did you patient first consult you for this condition (mm/dd/yy)? _____

3. If the loss of limbs was not a result of an accident, when did your patient first suffer symptoms or become aware of this condition (mm/dd/yy)?

_____

4. Please describe the following:

   a) Which limbs are affected? _____

   b) Level at which severance occurred for the affected limbs.

   _____

   c) The underlying cause of this condition. _____

5. Is the loss of limbs permanent without any contemplation of reattachment or transplantation?

_____

_____

_____

6. Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this condition?

Name of Physician or Hospital	**Address** (number, street, city, province, postal code)	**Date From** (mm/dd/yy)	**Date To** (mm/dd/yy)

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

7. Please provide results of all relevant investigations.

8. 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 reports.

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.