PRINT RESET

Wawanesa Life®

**Please return this completed form and supporting documents to:**
**Group Benefit Services**
**400-200 Main Street, Winnipeg, MB R3C 1A8**
**For inquiries, please call 1-800-665-7076**

# CRITICAL ILLNESS
## PHYSICIAN STATEMENT
## DEMENTIA INCLUDING ALZHEIMER'S DISEASE

### PATIENT AUTHORIZATION

Patient _____ Group Plan #_____
Last Name First Name

I hereby authorize the release of medical and health information in my file to Wawanesa Life and its authorized agents for the purpose of assessing my Group Critical Illness claim and administering the benefit plan. This medical and health information includes but is not limited to, copies of all consultation reports, the clinical notes, test results and hospital records. I understand that I am responsible for any fees related to the completion of this form.

I acknowledge that the personal information is required by Wawanesa Life for the purpose stated above. I acknowledge that my consent enables Wawanesa Life to process my claim and refusing to consent may result in delay or denial of my claim.

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photo copy or electronic copy of this authorization shall be as valid as the original.

_____ _____
Patient Signature Date (dd/mm/yyyy)

### CLINICAL INFORMATION

1. a) On what date did your patient first exhibit symptoms of Dementia or Alzheimer's Disease? What were they?

   b) On what date did your patient first consult you for these symptoms?_____

   c) How long has the Plan Member been your patient?_____

2. Please outline the clinical course and briefly describe your patient's neurological signs and symptoms, giving dates and durations.

3. On what date was the diagnosis of possible Dementia or Alzheimer's Disease first discussed with:
   a) Your patient?_____
   b) Your patient's family?_____

4. On what date was there the need for continuous daily supervision of your patient?

5. Please provide:
   a) Copy of the results and consultations done while investigating Dementia or Alzheimer's Disease.
   b) Names and addresses of other physicians consulted or hospitals attended by your patient for this disease.

   c) Confirm diagnosis: (Dementia or Alzheimer's Disease):_____

## CLINICAL INFORMATION

*CONTINUED*

5. d) Name and address of the neurologist who confirmed the diagnosis.

e) Is the patient followed by a gerontologist? ☐ Yes ☐ No
If 'Yes', please provide name, address and date last consulted.

6. Please provide any other information that would be helpful in the assessment of your patient's claim.

**Please provide copy of relevant clinical chart notes, test results, consultation reports and hospital summaries.**

Our plan requires that a Covered Condition be diagnosed by a physician who is not related to the Plan Member. Are you related to the Plan Member? ☐ Yes ☐ No

Physician's Name (Please Print) & Speciality

Phone Number

Physician's Signature

Date

**WHEN COMPLETE**
**Please send report to: The Wawanesa Life Insurance Company, Group Benefit Services, 400-200 Main Street, Winnipeg, Manitoba R3C 1A8**