



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
 CANCER**

<p>PATIENT AUTHORIZATION</p>	<p>Patient _____ Group Plan # _____ <small style="margin-left: 100px;">Last Name</small> <small style="margin-left: 150px;">First Name</small></p> <p>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.</p> <p>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.</p> <p>This consent may be revoked by me at any time by sending a written instruction.</p> <p>I confirm that a photo copy or electronic copy of this authorization shall be as valid as the original.</p> <p>_____ <small>Patient Signature</small></p> <p>_____ <small>Date (dd/mm/yyyy)</small></p>
<p>CLINICAL INFORMATION</p>	<p>1. a) On what date did your patient first exhibit symptoms? What were they? _____</p> <p>b) On what date did your patient first consult you for this condition? _____</p> <p>c) How long has the Plan Member been your patient? _____</p> <hr/> <p>2. a) On what date was this cancer diagnosed? By whom? _____</p> <p>b) On what date was your patient advised of the diagnosis? By whom? _____</p> <hr/> <p>3. Please provide a copy of the pathology report giving the following details: type of tumor, site of tumor, histology and staging. _____</p> <hr/> <p>4. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer. _____</p> <hr/> <p>5. What is treatment regimen? _____</p>

**CLINICAL
 INFORMATION**

CONTINUED

 6. a) Has your patient previously suffered from cancer or any predisposing disorders? Yes No
 If 'Yes,' please provide name, address and date last consulted.

 b) has your patient ever been tested for the Human Immunodeficiency Virus? Yes No
 If 'Yes,' please provide: Date: _____ Results: _____

7. 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**