



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  
 HEART ATTACK (MYOCARDIAL INFARCTION)**

<p><b>PATIENT          AUTHORIZATION</b></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><b>CLINICAL          INFORMATION</b></p>	<p>1. a) On what date did your patient first consult you for this condition? _____          b) How long has the Plan Member been your patient? _____</p> <p>2. a) Was a diagnosis of myocardial infarction made? <input type="checkbox"/> Yes <input type="checkbox"/> No          b) On what date was the diagnosis made? _____          c) By whom was the diagnosis made? Please provide name and specialty.           d) Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this heart attack?</p> <p>3. Please provide the following details pertaining to your patient's myocardial infarction:          a) Description and date of onset of chest pain.           b) ECG changes in detail at time of event or provide copies of tracing, if available.           c) Cardiac enzyme levels, including MB Band, at time of event.</p> <p>4. What other investigations have been performed? Please provide dates and details.</p>

**CLINICAL  
 INFORMATION**
*CONTINUED*

5. When did your patient first exhibit symptoms or episodes of cardiovascular disease? Please provide details and dates.

6. What is treatment regimen?

7. Please describe, including dates, any predisposing conditions or risk factors which your patient has had for cardiovascular disease.

8. 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**