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
MAJOR ORGAN TRANSPLANT

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. Please provide complete details of the disorder leading to your patient's transplant procedure.

2. a) On what date did your patient first exhibit symptoms of this disorder? What were they?

   b) On what date was the disorder first diagnosed?____________________

   c) On what date was your patient made aware of the diagnosis? By whom?

3. How long has the Plan Member been your patient?____

4. How long had end stage disease been present?____

5. a) Please give details of the transplant procedure performed, including the name and address of the hospital, the attending surgeon/physician and the date of the procedure.

   b) What is post transplant treatment regimen?

   c) What are your patient's medical restrictions and limitations?

Wawanesa Life®

CLINICAL INFORMATION

CONTINUED

6. Please describe, including date, any predisposing disorders or risk factors your patient had for the underlying disorder.

7. Please provide the names and addresses of other physicians attended by your patient for this or any related condition.

8. Is there anything in your patient's habits or family history that increased the risk of the underlying disorder? ☐ Yes ☐ No If 'Yes', please provide details.

9. 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

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