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
STROKE

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 consult you for this condition? _____
   b) How long has the Plan Member been your patient? _____

2. a) Was a diagnosis of stroke made? ☐ Yes ☐ No
   b) On what date did the stroke occur? _____
   c) By whom was the diagnosis made? Provide names and specialty.
   d) On what date was the patient advised of the diagnosis? By whom?

3. Please provide the following details pertaining to the insured's stroke:
   a) Please describe the stroke.
   b) Please describe the residual neurological deficits.
   c) How long have the neurological deficits persisted?

CLINICAL INFORMATION

CONTINUED

4. a) What mobility aids (if any) have been prescribed?

   b) What is current treatment regimen?

5. When did your patient first suffer symptoms or episodes of cerebrovascular disease? What were they? Please provide details and dates.

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

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