



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  
 MULTIPLE SCLEROSIS**

**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) On what date did your patient first have symptoms? What were they?

b) Please outline the clinical course and briefly describe your patients's neurological signs and symptoms, giving dates and durations.

- c) On what date was the diagnosis of possible Multiple Sclerosis first discussed with your patient?

3. Please provide:

a) A copy of the imaging report confirming the diagnosis.

b) Names and addresses of other physicians consulted or hospitals attended by your patient for this condition.

c) Name and address of the neurologist who confirmed the diagnosis.

**CLINICAL  
INFORMATION**

*CONTINUED*

4. a) What are your patient's medical restrictions and limitations?

b) What mobility aids (if any) are prescribed?

c) What is treatment regimen?

5. 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**