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

DISABILITY
SUPPLEMENTARY MEDICAL INFORMATION
PHYSICIAN STATEMENT

PATIENT AUTHORIZATION
To be completed by patient

Patient _____ Group Plan # _____
Last Name First Name

I hereby authorize the release of medical and health information in my file to Wawanesa Life and/or its authorized agents for the purpose of assessing my disability 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
To be completed by physician

Primary diagnosis:

Current symptoms and their severity:

How have these symptoms changes to date?

Has your patient & condition: ☐ recovered ☐ improved ☐ not improved ☐ deteriorated

List any secondary diagnoses or complications:

Is your patient: ☐ Ambulatory ☐ Ambulatory with assistive devices ☐ Bed confined ☐ Home confined ☐ Hospital confined

TREATMENT INFORMANT

Other treating/consulting physicians or health care practitioners:

Name of practitioner	Type of practitioner	Date seen (yy/mm/dd)

TREATMENT INFORMANT

Current medications:

Name	Dosage	Duration	Start Date (yy/mm/dd)	Response

Other forms of treatment or therapies:

Type	Duration	Start Date (yy/mm/dd)	Response

Hospitalizations:

Admission dates (yy/mm/dd)	Discharge dates (yy/mm/dd)	Facility	Reason (date of surgery if applicable)

Is your patient following the recommended treatment program? ☐ Yes ☐ No

If 'No', please explain:

Please provide details of any proposed changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy etc.

COMPETENCY

Is the patient capable of handling his/her own financial affairs? ☐ Yes ☐ No

If 'No', from what date?_____ (yy/mm/dd)

RETURN TO WORK

In your opinion, what is the earliest date your patient will be able to return to work?_____ (yy/mm/dd)

Is the patient able to participate in a rehabilitation program? ☐ Yes ☐ No Please explain:

REMARKS

Please provide any additional information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment; etc.

Please attach a copy of your patient's chart notes, including consultation reports and test results related to your patient's diagnosis.

PHYSICIAN INFORMATION

Name of Physician_____ Specialty_____

Telephone_____ Fax_____

Address_____ _____ _____ _____
Street & Number | City | Province | Postal Code

The information in this statement will be kept in a group, life health or disability benefits file with Wawanesa Life and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

_____ _____
Physician Signature | Date signed (yy/mm/dd)