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CRITICAL ILLNESS BENEFIT CLAIM FORM
PROOF OF CLAIM – CLAIMANT'S STATEMENT

Group Operation
400 – 200 Main Street, Winnipeg, MB R3C 1A8 1-800-665-7076

PLAN SPONSOR/PLAN MEMBER IDENTIFICATION

Policy # _____ Policy Sponsor _____ Plan Member ID WLI _____

Plan Member _____ _____
First Name Last Name

NOTE: This form should only be completed after the waiting period for your illness has been satisfied. Please refer to your policy contract for the appropriate waiting period.

CLAIM AND RELATED DETAILS

1. Please describe the nature and extent of your Critical Illness:

On what date was your condition diagnosed or surgery performed? _____

2. On what date did symptoms first commence? _____
Please describe these symptoms

3. On what date did you first consult a medical practitioner in connection with your illness? _____
Please indicate the name of the Physician seen

4. Have you undergone any tests or investigations related to the diagnosis? ☐ YES ☐ NO If 'YES', please provide details, including dates:

5. Have you previously suffered from, or received treatment for, a similar or related illness? ☐ YES ☐ No If 'YES', provide details, including dates.

MEDICAL CONSULTATIONS

6. Please provide the name and address of your personal physician:

7. Please provide details of any other doctors or specialists who have been consulted in connection with your illness:

Name	Address	Dates Seen

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8. If you have been treated at a hospital or a similar institution , please supply the following information:

Name of Hospital	City or Town	Date of Admission	Date of Discharge

9. What other treatment have you received or are you currently receiving in connection with your illness? (e.g. medications, therapy)

Type of Treatment	Institution/Prescribing Physician	Dates

GENERAL

10. Will you be claiming for benefits related to this illness from any other company? ☐ YES ☐ NO If 'YES', please indicate:

Name of Insurer	Type of Benefit	Benefit Amount	Has a claim been submitted?

11. Please provide any further information which you think might be helpful in support of your claim:

AUTHORIZATION

I hereby authorize any physician or practitioner, hospital, clinic or other medical or medically related facility that I have attended, and any insurance company, government agency, provincial health insurer, Canada Revenue Agency, institution, organization or person, that has any records or knowledge of me or my health to release full particulars thereof including all prior medical history and present condition to The Wawanesa Life Insurance Company, its reinsurers or its Associates for the purposes of administering my Critical Illness Claim.

I also authorize my insurer, or its reinsurers, to exchange the personal information obtained during my application for this policy, or any claim under this policy, with the insurer's Agents, affiliates, reinsurers and any other of my insurers. I further authorize my insurer to include this personal information in any other files which my insurer currently holds respective of me, or which may be opened in the future by my insurer, for use in accordance with the object of such other files.

A Photostat of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim. I understand that by furnishing this form and investigating the claim or by accepting proofs of claim, The Wawanesa Life Insurance Company shall not be held to admit the validity of any claim and not to have waived any of its rights in defense of any claim arising under the policy.

CONSENT & DISCLOSURE REGARDING PERSONAL INFORMATION

I consent to Wawanesa Life collecting, using and disclosing my personal information for the purposes of: establishing and maintaining communications with me; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet my needs; compiling statistics and acting as required or authorized by law.

I understand that Wawanesa Life may share my personal information with the following people, organizations and service providers: Wawanesa Life employees and agents who require this information to perform their jobs; claims investigators, investigative agencies, providers of information processing and storage, programming, printing, mailing and distribution services; applicable reinsurance companies; people to whom I have granted access; and people who are legally authorized to view my personal information. These people, organizations and service providers may be in other provinces or in jurisdictions outside Canada. My information may be shared as required by the laws of those jurisdictions.

I understand that any restriction or withdrawal of my consent may result in Wawanesa Life being unable to process the claim being applied for.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy and practices concerning service providers outside Canada from the Wawanesa Life Head Office at 400-200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

If you have a question (including a question concerning our collection of personal information, or the collection, use, disclosure or storage of personal information by service providers outside Canada on our behalf) or complaint regarding our privacy policies or procedures, please contact the individual accountable for our personal information protection compliance:
Vice Present, General Counsel and Secretary, The Wawanesa Life Insurance Company, 900 – 191 Broadway, Winnipeg, Manitoba R3C 3P1

DECLARATION AND SIGNATURE

I hereby acknowledge that the above is complete and accurate.

Date	Signature of Insured Member	Telephone Number

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