Physician Statement
Critical Illness

PLEASE PRINT

Name of patient: _____ _____
Surname First Name Date of Birth (mm/dd/yy)

Address: _____ _____
Number & Street City Province Postal Code

Telephone _____

Signature of Patient _____

PERSONAL INFORMATION CONSENT: The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Wawanesa Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy office.

1. Diagnosis Name_____Date of Diagnosis (mm/dd/yy)_____

   a) Please describe the clinical symptoms: _____

   _____

   _____

   b.) **Please provide copies of, but not limited to, investigative test results, imaging, pathology report, laboratory results, surgery reports etc. that support the above diagnosis.**

   c.) **Please provide copies of hospitalization records if applicable.**

2. Are you the patient's treating specialist? Yes ☐ No ☐

   If No, provide name of treating specialist_____

3. Date symptoms first appeared (mm/dd/yy): _____

4. Date patient first consulted you for this condition (mm/dd/yy): _____

5. Has the patient ever had the same or similar condition? Yes ☐ No ☐

   If yes, when and describe: _____

   _____

6. Is the patient still under your care for this condition? Yes ☐ No ☐

7. What treatment is planned or currently undergoing? _____

   _____

   _____

   _____

THE WAWANESA LIFE INSURANCE COMPANY
400-200 Main Street, Winnipeg, Manitoba R3C 1A8
Tel: (204) 985-3940 or 1-888-997-9965
Fax: 1-888-985-3872
www.wawanesalife.com Email: life@wawanesa.com

8. Do you foresee any delay in completing the planned treatment? Yes ☐ No ☐

   If yes, please describe _____

9. Please give the name and address of all consultants, specialists, or hospitals to which your patient has been referred or attended for this condition:

Doctor's Name

Address (Number, Street, City, Province, Postal Code)

Doctor's Name

Address (Number, Street, City, Province, Postal Code)

10. If there is any further information which, in your opinion, will assist our Team in assessing this claim? Please give details e.g predisposing disorders or risk factors:

Name (Please print)

Specialty

Street Address

City Province Postal Code

Area Code & Telephone Number

FAX number

Date (mm/dd/yy)

MD

Signature

This form is to be completed by a physician licensed in Canada whose practice is limited to the particular branch of medicine relating to the applicable critical illness. The INSURED is responsible for the completion of this form without expense to the Company.