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

Print Reset

POLICY #_____

PERSONAL DETAILS

NAME _____ DATE OF BIRTH ___ ___ ___ (DAY MONTH YEAR)

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE ___ ___ ___ ___ ___ ___

PHONE NUMBERS: HOME ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ BUSINESS ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

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

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. Has any blood relative suffered from a similar or related illness? ☐ YES ☐ NO If 'YES', please indicate:

Relationship	Nature of Illness	Age at first diagnosis

11. 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?

12. Do you smoke or use tobacco products? ☐ YES ☐ NO

If 'YES', amount per day: _____ How long have you used tobacco? _____

If 'NO', did you previously use tobacco products? ☐ YES ☐ NO On what date did you quit? _____

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

AUTHORIZATIONS

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.

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; claim 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 Executive 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: Privacy Officer, The Wawanesa Life Insurance Company, 400-200 Main Street, Winnipeg, Manitoba R3C 1A8.

DECLARATION AND SIGNATURE

I hereby declare that the foregoing answers are true and complete; that, to the best of my knowledge and belief, I have withheld no material facts from the Company and that the foregoing answers and statements are made with the object of securing the benefit claimed.

I confirm that I have read, understood and accepted the terms and conditions contained in the Consent & Disclosure Regarding Personal Information.

I authorize all physicians and other persons who have attended the deceased and all hospitals, institutions and government authorities to furnish to the Wawanesa Life Insurance Company all information in their possession or within their knowledge respecting the deceased.

A photocopy or an electronic reproduction of this document will be as valid as the original.

_____ _____

DATE SIGNATURE OF CLAIMANT

PLEASE RETURN FORM TO: The Wawanesa Life Insurance Company, 400 – 200 Main Street, Winnipeg, MB R3C 1A8, FAX 1-888-985-3872

LIMITATION PERIOD NOTICE

Every action or proceeding against the Company for a recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation. Limitation period can be suspended if the claimant provides satisfactory evidence that their disability prevented them from taking action within the Limitation Period.