

ATTENDING PHYSICIAN/APPLICANT INFORMATION

NAME OF ATTENDING PHYSICIAN

ADDRESS OF ATTENDING PHYSICIAN

NAME OF APPLICANT

DATE OF BIRTH

DAY MONTH YEAR

DETAILS

1. Please take 3 or more blood pressure readings, preferably at 5 minute intervals.

SYSTOLIC**DIASTOLIC** (at cessation of sound)

2. Has the applicant:

(a) Ever been told that his/her blood pressure has been elevated?

 YES NO If "YES", please provide details, including dates, type of therapy and names of doctors consulted).

(b) Ever received treatment for blood pressure?

 YES NO If "YES", please provide details, including dates, type of therapy and names of doctors consulted).

3. If the applicant has had an electrocardiogram, please attach a copy.

SIGNATURE

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

Attending Physician's Signature: _____ Date:

PLEASE RETURN FORM TO:**The Wawanesa Life Insurance Company, 400-200 Main Street, Winnipeg, MB R3C 1A8, TEL: 1-888-997-9965, FAX: 1-888-985-3872**