CRITICAL ILLNESS INSURANCE
CONFIDENTIAL PHYSICIAN'S STATEMENT
DEAFNESS

Print Reset

POLICY NUMBER(S)	

INSTRUCTIONS:
Please print. Part I to be completed by patient. Part II to be completed by physician. The patient is responsible for any fee for this information.

PART I – PATIENT IDENTIFICATION, AUTHORIZATION, AND CONSENT REGARDING PERSONAL INFORMATION

NAME _____ DATE OF BIRTH DD MM YYYY

ADDRESS _____

I hereby authorize the release to my insurer and my policyholder of any information in respect of this claim. A photocopy or an electronic reproduction of this document will be as valid as the original.

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.

Date _____ Patient's Signature _____

PART II – ATTENDING PHYSICIAN'S STATEMENT

1. When did your patient first consult you for hearing or related problems?

2. How long has this person been your patient?

3. On what date did your patient first suffer symptoms or become aware of hearing loss? Please provide details.

4. a) What is the auditory threshold in each ear?

   b) Please give the date of the first audiogram that established this. Please provide a copy of the audiogram if available.

   c) Please provide the name and address of the otolaryngologist.

5. a) What is the cause of the hearing loss?

b) Is this hearing loss permanent?

c) Is there any treatment that could improve the hearing?

6. Please describe, including dates, any predisposing disorders or risk factors your patient had for hearing loss.

7. Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related disorder.

8. Please provide details of any significant family history.

9. Please provide details of your patient's tobacco use including amount per day and date last used.

10. Please provide any other information that would be helpful in the assessment of your patient's claim.

***** Please provide copies of any specialist or hospital records for our Medical Director's review. *****

Our contract requires that a covered illness be diagnosed by a physician who is not related to or in business relationship with the insured. Are you related to or in business relationship with the patient? ☐ YES ☐ NO

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

_____ _____

Physician's Name (please print) Phone Number

_____ _____

Physician's Signature Date

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION

PLEASE SEND REPORT TO:

The Wawanesa Life Insurance Company,
400 – 200 Main Street, Winnipeg, Manitoba R3C 1A8
TOLL FREE: 1-888-997-9965 FAX: 1-888-985-3872 WEBSITE: wawanesalife.com