# CRITICAL ILLNESS INSURANCE
## CONFIDENTIAL PHYSICIAN'S STATEMENT
### ALZHEIMER'S DISEASE

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. a) On what date did your patient first suffer symptoms or episodes of Alzheimer's Disease? What were they?

   b) On what date did the patient first consult you for these symptoms?

   c) How long has the insured been your patient?

2. Please outline the clinical course and briefly describe the patient's neurological signs and symptoms, giving dates and durations.

3. On what date was the diagnosis of possible Alzheimer's disease first discussed with:
   a) The patient?

   b) The family?

4. On what date was there the need for continuous daily supervision of the patient?

5. Please provide:

A: Copy of the test results and consultations done while investigating Alzheimer's disease.

B: Names and addresses of other physicians consulted or hospitals attended by your patient for this disease.

C: Name and address of the neurologist who confirmed the diagnosis.

D: Is the patient followed by a gerontologist? ☐ YES ☐ NO
If 'YES', please provide name, address and date last consulted.

6. Is there a family history of Alzheimer's disease? ☐ YES ☐ NO
If 'YES', please provide details.

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

8. 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**
**FAX: 1-888-985-3872**