



CRITICAL ILLNESS INSURANCE CONFIDENTIAL PHYSICIAN'S STATEMENT BENIGN BRAIN TUMOUR

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 have symptoms? What were they?

b) On what date did the patient first consult you for this condition?

c) How long has the insured been your patient?

2. a) On what date was the brain tumour diagnosed? By whom?

b) On what date was the patient advised of the diagnosis? By whom?

c) Does the brain tumour require surgical removal?

3. Please provide a copy of the CT scan or MRI confirming the diagnosis.

4.	Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this tumour.
5.	Has your patient previously suffered from this condition or any predisposing disorders? <input type="checkbox"/> YES <input type="checkbox"/> NO If 'YES', please provide dates and details.
6.	a) Is there a family history of brain tumours? <input type="checkbox"/> YES <input type="checkbox"/> NO If 'YES', please provide details.
	b) Please provide details of any other significant family history.
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? <input type="checkbox"/> YES <input type="checkbox"/> 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