

POLICY NUMBER(S)	
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**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](http://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.*

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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 this cancer diagnosed? By whom?
	b)	On what date was the patient advised of the diagnosis? By whom?
3.	Please provide a copy of the pathology report giving the following details: type of tumor, site of tumor, histology and staging.	
4.	Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer.	

5.	a) Has your patient previously suffered from cancer or any predisposing disorders? <input type="checkbox"/> YES <input type="checkbox"/> NO If 'YES', please provide dates and details.
	b) Has your patient ever been tested for the Human Immunodeficiency Virus? <input type="checkbox"/> YES <input type="checkbox"/> NO If 'YES', please provide:  Date: _____ Result: _____
6.	a) Is there a family history of cancer? <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.
<b>*** Please provide copies of any specialist or hospital records for our Medical Director's review. ***</b>	
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
<b>THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION</b>	

**PLEASE SEND REPORT TO:**  
**The Wawanesa Life Insurance Company,**  
**400 – 200 Main Street, Winnipeg, Manitoba R3C 1A8**  
**FAX: 1-888-985-3872**