CRITICAL ILLNESS INSURANCE
CONFIDENTIAL PHYSICIAN'S STATEMENT
FAILURE OF BOTH KIDNEYS

POLICY NUMBER(S)	

Print Reset

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) How long has this person been your patient?

b) On what date did your patient first suffer symptoms or become aware of renal disease or impaired renal function? What were they?

c) When did your patient first consult you for renal disease?

2. Does your patient have end stage irreversible failure of both kidneys? ☐ YES ☐ NO

3. What is the cause of the renal failure?

4. a) On what date did your patient first start dialysis?

b) Is regular renal dialysis being performed?

c) Has a renal transplant taken place or is it proposed for the future?

5. Please provide results of relevant investigations and laboratory results.

6. Please give the names and addresses of other physicians consulted or hospitals attended by the patient for this condition.

7. Please describe, including dates, any predisposing disorders or risk factors the patient had for renal disease, e.g. diabetes, hypertension.

8. Is there a family history of renal disease? ☐ YES ☐ NO If 'YES', please provide details.

9. Please provide details of any other significant family history.

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

11. 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