Print Reset

CLAIMANT'S STATEMENT OF CONTINUING DISABILITY

POLICY NUMBER(S)_____

PERSONAL DETAILS

NAME _____ DATE OF BIRTH ____ ____ ____ (DAY MONTH YEAR)

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____ _____

PHONE NUMBERS: HOME ___ - ___ - ____ BUSINESS ___ - ___ - ____

CLAIM AND RELATED DETAILS

1. Please describe any changes in your condition since last report (include details of any hospitalization):

2. Dates you have seen your regular doctor since last report:

3. Have you seen any other physicians/specialists since last report? ☐ YES ☐ NO If YES, please provide details:

Physician's/Specialist's Name	Address	Specialty	Dates Seen From	Dates Seen To

4. Investigations since last report (e.g. EKGs, x-rays, lab tests etc.):

Type of Investigation	Date Carried Out	Summary of Results (attach copies of all available reports)

5. Any further investigations planned? ☐ YES ☐ No If 'YES', state type and when:

6. (a) Have you returned to work? ☐ YES ☐ NO If YES, when did you begin work? D M Y

Indicate: ☐ Full-time ☐ Part-time ☐ Usual job ☐ New job/duties ☐ Work hardening

If NO, when do you expect to return to your previous or any other job? D M Y

(b) Are you retraining or trying to do so? ☐ YES ☐ NO Please provide details:

(c) Describe daily activities:

7. Please outline below **any** income you are currently receiving or have applied for, such as Worker's Compensation, Group/Individual Disability Benefits, salary/wage continuance/pension through employer, Government Disability or Pension. Please attach copies of any correspondence related to the above, award notice or cheque stub.

Source of Income	Date Applied	Date Income Commenced	Amount of Payments	Frequency of Payments

8. If you are **not** currently receiving any disability benefits or income, please indicate below if any and when you will be applying. If you are not planning to apply, please provide the reasons for not applying.

AUTHORIZATIONS

I hereby authorize any physician or practitioner, hospital, clinic or other medical or medically related facility that I have attended, and any insurance company, government agency, provincial health insurer, Canada Revenue Agency, institution, organization or person, that has any records or knowledge of me or my health to release full particulars thereof including all prior medical history and present condition to The Wawanesa Life Insurance Company, its reinsurers or its Associates for the purposes of administering my claim.

I also authorize my insurer, or its reinsurers, to exchange the personal information obtained during my application for this policy, or any claim under this policy, with the insurer's Agents, affiliates, reinsurers and any other of my insurers. I further authorize my insurer to include this personal information in any other files which my insurer currently holds respective of me, or which may be opened in the future by my insurer, for use in accordance with the object of such other files.

I understand that by furnishing this form and investigating the claim or by accepting proofs of claim, The Wawanesa Life Insurance Company shall not be held to admit the validity of any claim and not to have waived any of its rights in defense of any claim arising under the policy.

CONSENT & DISCLOSURE REGARDING PERSONAL INFORMATION

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.

DECLARATION AND SIGNATURE

I hereby declare that the foregoing answers are true and complete; that, to the best of my knowledge and belief, I have withheld no material facts from the Company and that the foregoing answers and statements are made with the object of securing the benefit claimed.

I confirm that I have read, understood and accepted the terms and conditions contained in the Consent & Disclosure Regarding Personal Information.

I authorize all physicians and other persons who have attended the deceased and all hospitals, institutions and government authorities to furnish to the Wawanesa Life Insurance Company all information in their possession or within their knowledge respecting the deceased.

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

DATE _____ SIGNATURE OF CLAIMANT _____

PLEASE RETURN FORM 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

LIMITATION PERIOD NOTICE

Every action or proceeding against the Company for a recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.