ATTENDING PHYSICIAN'S INITIAL LONG-TERM DISABILITY BENEFITS STATEMENT

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 D M Y

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. History

(a) Date symptoms first appeared or accident happened: D M Y

(b) Date patient ceased work because of current condition: D M Y

(c) Is condition due to injury or sickness arising out of patient's employment? ☐ YES ☐ NO ☐ UNKNOWN

(d) Has patient ever had same or similar condition? ☐ YES ☐ NO ☐ UNKNOWN If YES, please provide details:

(e) Is condition considered chronic? ☐ YES ☐ NO If YES, what precipitated absence from work?

(f) Names of other treating physicians:

2. Diagnosis (including any complications)

(a) Primary:

(b) Additional conditions or complications which might affect duration of absence from work:

(c) Subjective symptoms:

(d) Objective signs (including results of current x-rays, EKGs or laboratory data and any relevant clinical findings):

3. Physical Impairment

What physical limitations affect the claimant's ability to work (e.g. limitations with respect to lifting, carrying, bending, walking?

4. Mental/Nervous Impairment

(a) How does patient's mental or nervous impairment affect ability to work?

(b) Has there been psychiatric referral? ☐ YES ☐ NO

(c) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ☐ YES ☐ NO

5. Cardiac (if applicable)

(a) Functional capacity (American Heart Association): ☐ Class 1 (no limitations) ☐ Class 3 (marked limitations) ☐ Class 2 (slight limitations) ☐ Class 4 (complete limitations)

Please forward results of exercise tests, angiogram, or other relevant documentation.

(b) Blood pressure (last visit): Systolic: _____ Diastolic: _____

6. Treatment

(a) Date of first visit: D | M | Y Date of latest visit: D | M | Y

(b) Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (please specify): _____

(c) Nature of treatment (including surgery, physiotherapy and medications prescribed, if any):

(d) To your knowledge, is patient following the recommended treatment program? ☐ YES ☐ NO (please comment):

7. Progress

Has patient: ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

8. Prognosis

(a) Do you think the patient will be able to return to former occupation? ☐ YES (provide approx. date) ☐ NO (provide reasons)

(b) Do you think patient will be able to perform any occupation? ☐ YES (provide approx. date) ☐ NO (provide reasons)

9. Rehabilitation

(a) Is patient a suitable candidate for further medical rehabilitation services? ☐ YES (specify) ☐ NO (provide reasons)

(b) Would vocational counseling and/or retraining be recommended? ☐ YES ☐ NO (provide reasons)

(c) Is patient suitable for trial employment? ☐ YES (provide approx. date) ☐ NO (provide reasons)

10. Tobacco Usage

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

11. Remarks

Please provide any further details which you feel would be helpful.

ATTENDING PHYSICIAN INFORMATION AND SIGNATURE

NAME _____ SPECIALTY _____ TEL. _____

ADDRESS _____

DATE _____ SIGNATURE _____

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION

WHEN COMPLETE PLEASE SEND REPORT TO:

The Wawanesa Life Insurance Company, 400-200 Main Street, Winnipeg, MB R3C 1A8, FAX: 1-888-985-3872