Aplastic Anemia

Physician's Statement (Specialist only)

PLEASE PRINT

Name of patient: _____ _____
Surname First Name Date of Birth (mm/dd/yy)

Address: _____
Number & Street City Province Postal Code

Telephone ( ) _____

1. a) On what date did your patient first consult you for this condition (mm/dd/yy)? _____

   b) How long has this person been your patient? _____

   c) When did the patient first exhibit symptoms relative to the final diagnosis of aplastic anemia (mm/dd/yy)? _____
   What symptoms were experienced by your patient?

   _____

2. Was a biopsy performed? If yes, please provide date, name of physician and a copy of the applicable test results?

   _____

   _____

3. Was a blood product transfusion performed? If yes, please provide date of such treatment and confirm the name of the physician who performed the procedure.

   _____

   _____

4. Please confirm if your patient received any of the following treatments:

Marrow Stimulating agents	❒ Yes	❒ No	Dates (mm/dd/yy)	_____
Immunosuppressive agents	❒ Yes	❒ No	Dates (mm/dd/yy)	_____
Bone marrow transplantation	❒ Yes	❒ No	Dates (mm/dd/yy)	_____

5. a) Please provide the date that the diagnosis of aplastic anemia was determined (mm/dd/yy): _____

   b) On what date (mm/dd/yy) the patient advised of the diagnosis and by whom:

   _____

   _____

6. Please provide details of relevant investigations and laboratory results?

   _____

   _____

   _____

THE WAWANESA LIFE INSURANCE COMPANY
236 Carlton St, Winnipeg, Manitoba R3C 1P5
Tel: 1-844-318-0411, #3 Fax: 1-855-496-3028
Email: WawanesaLife-claims@wawanesa.com
wawanesalife.com

7. Please indicate if patient has any predisposing disorders or risk factors for aplastic anemia.

8. Is there a family history of aplastic anemia? ❒ Yes ❒ No

Please give details.

9. Please give below any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of any specialist or hospital reports.

Name (Please print) | Degree

Street Address | City | Province | Postal Code

Area Code & Telephone Number | FAX number

Date (mm/dd/yy) | Signature MD

This form is to be completed by a physician licensed in Canada whose practice is limited to the particular branch of medicine relating to the applicable critical illness. The INSURED is responsible for the completion of this form without expense to the Company.

PERSONAL INFORMATION CONSENT: The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Wawanesa Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy officer.

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