Motor Neuron Disease

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 have symptoms (mm/dd/yy)? What were they?

_____

_____

_____

_____

b) When did your patient first consult you for this condition (mm/dd/yy)? _____

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

2. Please outline the clinical course and briefly describe the patient's neurological signs and symptoms, giving dates (mm/dd/yy) and durations.

_____

_____

_____

_____

3. On what date was the diagnosis of possible Motor Neuron Disease first discussed with the patient (mm/dd/yy)? _____

4. Please provide:
   a) A copy of the test results confirming the diagnosis.
   b) Names and addresses of other physicians consulted or hospitals attended by your patient for this condition.

Name of Physician or Hospital	**Address** (number, street, city, province, postal code)	**Date From** (mm/dd/yy)	**Date To** (mm/dd/yy)

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

c) Name and addresses of the neurologist who confirmed the diagnosis:

Name of Neurologist	Address (number, street, city, province, postal code)	Telephone No.
		( ) -
		( ) -

5. 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 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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