WAIVER OF PREMIUM
PHYSICIAN STATEMENT

Please return this completed form and supporting documents to:

Wawanesa Life - Claims
236 Carlton St, Winnipeg, MB R3C 1P5
For inquiries, please call: 1-844-318-0411, #4
Email: WawanesaLife-claims@wawanesa.com
Website: wawanesalife.com

PATIENT AUTHORIZATION

To be completed by patient

Patient _____ Group Plan # _____
Last Name First Name

I hereby authorize the release of medical and health information in my file to Wawanesa Life and/or its authorized agents for the purpose of assessing my disability claim and administering the benefit plan. This medical and health information includes, but is not limited to, copies of all consultation reports, the clinical notes, test results and hospital records. I understand that I am responsible for any fees related to the completion of this form.

I acknowledge that the personal information is required by Wawanesa Life for the purpose stated above. I acknowledge that my consent enables Wawanesa Life to process my claim and refusing to consent may result in delay or denial of my claim.

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photo copy or electronic copy of this authorization shall be as valid as the original.

_____ _____
Patient Signature Date (dd/mm/yyyy)

CLINICAL INFORMATION

To be completed by physician

Primary Diagnosis

Secondary Diagnoses or complications

Patient's height _____ Patient's weight _____ Dominant hand ☐ Right ☐ Left

Date of accident/symptoms onset _____ (yy/mm/dd)

Date condition first prevented patient from working _____ (yy/mm/dd)

Is this condition due to:

☐ Motor vehicle accident ☐ Work ☐ Other (Please specify) _____

Current symptoms (include frequency and severity)

How have the symptoms changed to date?

Is your patient's condition related to issues at the workplace? ☐ Yes ☐ No

Clinical findings

Has the patient had this condition before? ☐ Yes ☐ No

If 'Yes', when?

Wawanesa Life®

CLINICAL INFORMATION

continued

Have there been any changes in your patient's Activities of Daily Living? ☐ Yes ☐ No

Is your patient: ☐ Ambulatory ☐ Ambulatory with assistive devices ☐ Bed confined ☐ Home confined ☐ Hospital confined

Currently, what is your patient's physical ability relative to the below activities:

	Hours at one time					Total hours during day					
	<1	1-2	2-4	4-6	>6	<1	1-2	2-4	4-6	>6	
Sitting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ No restriction
Standing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ No restriction
Walking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ No restriction
Driving	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ No restriction

Lifting / Carrying	0-10 lbs	11-20 lbs	21-50 lbs	Infrequent	Frequent	Constant
Lifting-floor to waist	☐	☐	☐	☐	☐	☐
Lifting-waist to shoulder	☐	☐	☐	☐	☐	☐
Lifting-above shoulder	☐	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐	☐

PSYCHIATRIC

If disability relates to or includes psychologic symptoms

Aligning with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or similar:

Provide diagnosis and ICD-9 or ICD10 code

Current Symptoms and their severity

Is the patient's condition related to drug or alcohol abuse? ☐ Yes ☐ No

Is/has the patient currently or previously enrolled in a substance abuse program? ☐ Yes ☐ No

If 'Yes', state when and what type of program?

Provide copy of relevant testing such as:
Patient Health Questionnaire - 9 (PHQ-9)
World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0).
If no such testing, why not?

VISION

If disability relates to vision

Provide visual acuity and date of last examination.

With corrective lenses _____ OD _____ OS

Without corrective lenses _____ OD _____ OS

Date of last exam _____ (yy/mm/dd)

PREGNANCY

If disability relates to pregnancy

If patient is pregnant, give Expected Date of Confinement_____ (yy/mm/dd)

Please provide copies of pre-natal records

TREATMENT INFORMATION

Date of first visit_____ (yy/mm/dd) Date of last visit_____ (yy/mm/dd)

Frequency of visits ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other (specify)_____

TREATMENT INFORMATION

Continued

Other treating/consulting physicians or health care practitioners:

Name of practitioner	Type of practitioner	Date seen (yy/mm/dd)

Current medications:

Name	Dosage	Duration	Start Date (yy/mm/dd)	Response

Other forms of treatment or therapies:

Type	Duration	Start Date (yy/mm/dd)	Response

Hospitalizations:

Admission dates (yy/mm/dd)	Discharge dates (yy/mm/dd)	Facility	Reason (date of surgery if applicable)

Treatment response: ☐ Recovered ☐ Improved ☐ No change ☐ Retrogressed

Comments:

Is your patient following the recommended treatment program? ☐ Yes ☐ No

If 'No', please explain:

Please provide details of any proposed changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy etc.

RETURN TO WORK

In your opinion, what is the earliest date your patient will be able to return to work?_____ (yy/mm/dd)

Is the patient able to participate in a rehabilitation program? ☐ Yes ☐ No Please explain:

COMPETENCY

Is the patient capable of handling his/her own financial affairs? ☐ Yes ☐ No

If 'No', from what date?_____ (yy/mm/dd)

LICENSE RESTRICTION

Has your patient's driver's license or any other professional license or certification been restricted, revoked or suspended as a result of the current condition? ☐ Yes ☐ No

☐ Restricted ☐ Revoked ☐ Suspended Date_____ (yy/mm/dd)

Type of license_____ Class of license_____

If 'Yes', when will your patient be eligible to apply for reinstatement of the license or certification?

Date_____ (yy/mm/dd)

REMARKS

Please provide any additional information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment; etc.

Please attach a copy of your patient's chart notes, including consultation reports and test results related to your patient's diagnosis.

PHYSICIAN INFORMATION

Name of Physician_____ Specialty_____

Telephone_____ Fax_____

Address_____ (Street & Number) _____ (City) _____ (Province) _____ (Postal Code)

The information in this statement will be kept in a group, life health or disability benefits file with Wawanesa Life and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

_____ Physician Signature _____ Date signed (yy/mm/dd)

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.