Aortic Surgery

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. When did your patient first consult you for disease of the aorta? Date (month, day, year) _____
   b. How long has this person been your patient? Date (month, day, year) _____
2. On what date did your patient first suffer symptoms or become aware of disease of the aorta? Please provide details
   Date (month, day, year) _____
3. To the best of your knowledge:
   a. When was this aortic disease first diagnosed? _____
   b. Who was the first doctor to diagnose this condition? _____
4. Please provide the name and address of the vascular surgeon(s) and cardiologist(s) who have seen this patient.

Name of Specialist	**Address** (number, street, city, province postal code)	**Telephone Number** (including area code)

5. Please describe the exact nature and location of the aortic disease.

   _____

   _____
6. Please provide a copy of any angiographic and ECHO studies of the aorta.
7. Please provide a copy of the operative report(s) for the aortic surgery.
8. Please provide copies of any specialist or hospital reports.
9. Does patient have other critical illnesses? ❒ Yes ❒ No
   If yes, please identify: _____

   _____

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.

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