DISABILITY SUPPLEMENTARY MEDICAL INFORMATION

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
Fax 1-855-496-3028
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 photocopy or electronic copy of this authorization shall be as valid as the original.

______________________________ Patient Signature

______________________________ Date (dd/mm/yy)

CLINICAL INFORMATION *To be completed by physician*

Primary diagnosis:

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____

Current symptoms and their severity:

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____

How have these symptoms changes to date?

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____

Has your patient & condition: ☐ recovered ☐ improved ☐ not improved ☐ deteriorated

List any secondary diagnoses or complications:

____

____

____

Is your patient: ☐ Ambulatory ☐ Ambulatory with assistive devices

☐ Bed confined ☐ Hospital confined ☐ Home confined

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TREATMENT INFORMATION

Other treating/consulting physicians or health care practitioners:

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

Current medications:

Other forms of treatment or therapies:

Hospitalizations:

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.

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COMPTENCY

Is the patient capable of handling their own financial affaris? ☐ Yes ☐ No If 'No', from what date?_____________
(yy/mm/dd)

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:

____

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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.

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PHYSICIAN INFORMATION

Name of Physician____ Specialty____________________________________

Address ________________________________ ______________ _______ ______________
Street & Number City Province Postal Code

Telephone _________________ Fax __________________

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 grantedor those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

________________________________ _____________________
Physician Signature Date signed (dd/mm/yy)

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

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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