



**CRITICAL ILLNESS BENEFIT**  
**CONFIDENTIAL PHYSICIAN'S STATEMENT**  
**ALZHEIMER'S DISEASE**

Group Operation  
400 – 200 Main Street, Winnipeg, MB R3C 1A8 1-800-665-7076

**EMPLOYER/EMPLOYEE IDENTIFICATION**

Policy # \_\_\_\_\_ Employer Name \_\_\_\_\_ Claimant ID WLI \_\_\_\_\_

Employee Name \_\_\_\_\_  
First Name Last Name

**NOTE: This form should only be completed after the waiting period for your illness has been satisfied. Please refer to your policy contract for the appropriate waiting period.**

**CLAIM AND RELATED DETAILS**

1. a) On what date did your patient first suffer symptoms or episodes of Alzheimer's Disease? What were they?  
 \_\_\_\_\_

b) On what date did the patient first consult you for these symptoms?  
 \_\_\_\_\_

c) How long has the insured been your patient?  
 \_\_\_\_\_

2. Please outline the clinical course and briefly describe the patient's neurological signs and symptoms, giving dates and durations.  
 \_\_\_\_\_

3. On what date was the diagnosis of possible Alzheimer's disease first discussed with:  
 a) The patient?  
 \_\_\_\_\_

b) The family?  
 \_\_\_\_\_

4. On what date was there the need for continuous daily supervision of the patient?  
 \_\_\_\_\_

5. Please provide:  
 A: Copy of the test results and consultations done while investigating Alzheimer's disease.  
 B: Names and addresses of other physicians consulted or hospitals attended by your patient for this disease.  
 \_\_\_\_\_  
 C: Name and address of the neurologist who confirmed the diagnosis.  
 \_\_\_\_\_  
 D: Is the patient followed by a gerontologist?  YES  NO  
 If 'YES', please provide name, address and date last consulted.  
 \_\_\_\_\_

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6. 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 records for our Medical Director's review. \*\*\***

Our contract requires that a covered illness be diagnosed by a physician who is not related to the insured. Are you related to the patient?  YES  NO

\_\_\_\_\_  
Physician's Name (Please Print)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

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**WHEN COMPLETE**

**Please send report to: Medical Director, The Wawanesa Life Insurance Company, Group Operation  
400 – 200 Main Street, Winnipeg, Manitoba R3C 1A8**