



CRITICAL ILLNESS BENEFIT CONFIDENTIAL PHYSICIAN'S STATEMENT BLINDNESS

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. When did your patient first consult you for any eye problems?

2. How long has the insured been your patient?

3. On what date did your patient first suffer symptoms or become aware of any eye problem? Please provide details.

4. a) What is the corrected vision or the field of vision in each eye?
b) On what date was this test performed?
c) Please provide the name and address of the ophthalmologist.

5. a) What is the cause of the blindness?
b) Is the blindness permanent?
c) Is there any treatment that could improve your patient's vision?

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6. Please describe, including dates, any predisposing disorders or risk factors your patient had for blindness.

7. Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related disorder.

8. 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**