



**CRITICAL ILLNESS BENEFIT**  
**CONFIDENTIAL PHYSICIAN'S STATEMENT**  
**CANCER**

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 have symptoms? What were they?  
\_\_\_\_\_

b) On what date did the patient first consult you for this condition?  
\_\_\_\_\_

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

2. a) On what date was this cancer diagnosed? By whom?  
\_\_\_\_\_

b) On what date was the patient advised of the diagnosis? By whom?  
\_\_\_\_\_

3. Please provide a copy of the pathology report giving the following details: type of tumor, site of tumor, histology and staging.  
\_\_\_\_\_

4. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this cancer.  
\_\_\_\_\_

For Head Office Use Only

5.	a) Has your patient previously suffered from cancer or any predisposing disorders? <input type="checkbox"/> YES <input type="checkbox"/> NO If 'YES', please provide dates and details.
	b) Has your patient ever been tested for the Human Immunodeficiency Virus? <input type="checkbox"/> YES <input type="checkbox"/> NO If 'YES', please provide:  Date: _____ Result: _____
6.	Please provide any other information that would be helpful in the assessment of your patient's claim.
<b>*** Please provide copies of any specialist or hospital records for our Medical Director's review. ***</b>	
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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
_____ Physician's Name (Please Print)	_____ Phone Number
_____ Physician's Signature	_____ Date
For Head Office Use Only	

**WHEN COMPLETE**

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