



CRITICAL ILLNESS BENEFIT CLAIM FORM PROOF OF CLAIM – CLAIMANT’S STATEMENT

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. Please describe the nature and extent of your Critical Illness:

On what date was your condition diagnosed or surgery performed? _____

2. On what date did symptoms first commence? _____

Please describe these symptoms

3. On what date did you first consult a medical practitioner in connection with your illness? _____

Please indicate the name of the Physician seen

4. Have you undergone any tests or investigations related to the diagnosis? YES NO If 'YES', please provide details, including dates:

5. Have you previously suffered from, or received treatment for, a similar or related illness? YES No If 'YES', provide details, including dates.

MEDICAL CONSULTATIONS

6. Please provide the name and address of your personal physician:

7. Please provide details of any other doctors or specialists who have been consulted in connection with your illness:

Name	Address	Dates Seen

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8. If you have been treated at a hospital or a similar institution, please supply the following information:

Name of Hospital	City or Town	Date of Admission	Date of Discharge

9. What other treatment have you received or are you currently receiving in connection with your illness? (e.g. medications, therapy)

Type of Treatment	Institution/Prescribing Physician	Dates

GENERAL

10. Will you be claiming for benefits related to this illness from any other company? YES NO If 'YES', please indicate:

Name of Insurer	Type of Benefit	Benefit Amount	Has a claim been submitted?

11. Please provide any further information which you think might be helpful in support of your claim:

AUTHORIZATION

I hereby authorize any physician or practitioner, hospital, clinic or other medical or medically related facility that I have attended, and any insurance company, government agency, provincial health insurer, Canada Revenue Agency, institution, organization or person, that has any records or knowledge of me or my health to release full particulars thereof including all prior medical history and present condition to The Wawanesa Life Insurance Company, its reinsurers or its Associates for the purposes of administering my Critical Illness Claim.

I also authorize my insurer, or its reinsurers, to exchange the personal information obtained during my application for this policy, or any claim under this policy, with the insurer's Agents, affiliates, reinsurers and any other of my insurers. I further authorize my insurer to include this personal information in any other files which my insurer currently holds respective of me, or which may be opened in the future by my insurer, for use in accordance with the object of such other files.

A Photostat of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim. I understand that by furnishing this form and investigating the claim or by accepting proofs of claim, The Wawanesa Life Insurance Company shall not be held to admit the validity of any claim and not to have waived any of its rights in defense of any claim arising under the policy.

NOTICE CONCERNING PERSONAL INFORMATION

You have previously provided consent to Wawanesa Life for the collection, use and disclosure of your personal information for the purposes of: establishing and maintaining communications with you; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet your needs; compiling statistics and acting as required or authorized by law. That consent applied to personal information being provided to Wawanesa Life at that time and to personal information that may be provided after that time.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy from the Wawanesa Life Head Office at 400-200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

DECLARATION AND SIGNATURE

I hereby acknowledge that the above is complete and accurate.

_____ Date

_____ Signature of Insured Member

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