



**CRITICAL ILLNESS BENEFIT**  
**CONFIDENTIAL PHYSICIAN'S STATEMENT**  
**HEART ATTACK (MYOCARDIAL INFARCTION)**

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 the patient first consult you for this condition?

b) How long has the insured been your patient?

2. a) Was a diagnosis of myocardial infarction made?  YES  NO

b) On what date was the diagnosis made?

c) By whom was the diagnosis made? Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this heart attack.

3. Please provide the following details pertaining to the insured's myocardial infarction:

a) Description and date of onset of chest pain.

b) ECG changes in detail at time of event or provide copies of tracings, if available.

c) Cardiac enzyme levels, including MB Band, at time of event.

4. What other investigations have been performed? Please provide dates and details, or reports.

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5. When did your patient first suffer symptoms or episodes of cardiovascular disease? Please provide details and dates.

6. Please describe, including dates, any predisposing conditions or risk factors which your patient has had for cardiovascular disease.

7. 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**