Wawanesa Life®

Deafness

Physician's Statement (Specialist only)

PLEASE PRINT

♦ Name of patient: ______________________ ______________________ ______________________
Surname First Name Date of Birth (mm/dd/yy)

Address: ____
Number & Street City Province Postal Code

Telephone (   ) ______________________

1. A.) Date of Diagnosis: ______________________ (mm/dd/yy)

   B.) Indicate your diagnosis and cause of deafness. ______________________

   C.) Is deafness permanent? ❒ Yes ❒ No

2. A.) Date when patient first suffered symptoms or became aware of any hearing loss or problem (mm/dd/yy): __________

   B.) If loss of hearing was due to injury, provide details: ______________________

3. A.) Date patient first consulted you for any hearing problem (mm/dd/yy): ______________________

   B.) How long has this person been your patient? ______________________

4. Is the patient still under your care for this condition? ❒ Yes ❒ No

5. A.) What is the auditory threshold in each ear? __________ Right __________ Left

   B.) Give the date of the first audiogram that established this: ______________________ (mm/dd/yy)
   Provide a copy of the audiogram if available.

   C.) Provide name and address of otolaryngologist: ______________________

6. Describe including dates, any predisposing disorders or risk factors your patient had for hearing loss (mm/dd/yy):

7. Is there a family history of hearing loss? ❒ Yes ❒ No

   If yes, provide details: ______________________

THE WAWANESA LIFE INSURANCE COMPANY
236 Carlton St, Winnipeg, Manitoba R3C 1P5
Tel: 1-844-318-0411, #3 Fax: 1-855-496-3028
Email: WawanesaLife-claims@wawanesa.com
wawanesalife.com

8. Is there any treatment that could improve your patient's hearing? ❐ Yes ❐ No

If yes, provide details: ______________________________

9. Please give the name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition. Provide copies of any specialist or hospital reports for our Medical Director's review.

- Doctor's Name ______________________________

  Address ______________________________
  Street City Province Postal Code

- Doctor's Name ______________________________

  Address ______________________________
  Street City Province Postal Code

- Doctor's Name ______________________________

  Address ______________________________
  Street City Province Postal Code

10. If there is any further information which, in your opinion, will assist our Medical Director in assessing this claim, please give details:

____

____

Name (Please print)	Degree
Street Address	City Province Postal Code
Area Code & Telephone Number	FAX number
Date (mm/dd/yy)	Signature MD

This form is to be completed by a physician licensed in Canada whose practice is limited to the particular branch of medicine relating to the applicable critical illness. The INSURED is responsible for the completion of this form without expense to the Company.

PERSONAL INFORMATION CONSENT: The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among Wawanesa Life Insurance Company, their agents, affiliates, partners, subsidiaries, reinsurers, rating agencies and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacy@wawanesa.com or by calling 1-888-997-9965 and asking to speak to the Privacy office.r